Maternal and Child Health Services
Title V Block Grant

State Narrative for New Hampshire

Application for 2011
Annual Report for 2009

Document Generation Date: Saturday, September 18, 2010

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and certifications are maintained on file in the New Hampshire Title V program's central office at:

Maternal and Child Health Section
NH DHHS
29 Hazen Drive
Concord, NH 03301

Assurances and certifications are available on request by contacting the New Hampshire Maternal and Child Health Section, Division of Public Health Services, Department of Health and Human Services at the above address, or by phone at 603-271-4517, by email at dlcampbell@dhhs.state.nh.us , or via the NH MCH website at: http://www.dhhs.state.nh.us/DHHS/BMCH/CONTACT+INFO/default.htm

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

In order to validate the work of the Title V professionals in the state agency and in the field, it is imperative to have family and community input into priority setting and program evaluation. Public Input for the Title V 2010 Needs Assessment and 2011 Annual Report were combined and in mid-2009, the Title V developed and administered an on-line (Survey Monkey) and paper survey to collect public input on the health needs of NH families. A link to the on-line version was placed on the DHHS website and distributed electronically to statewide contacts of Title V staff, including Title V-funded health care agencies, other state agencies, committees, advisory groups, task forces and others. A total of 689 people returned the paper surveys and 299 people responded to the Survey Monkey version.

The paper survey was distributed to Title V-funded health care agencies and to the ten DHHS District Offices (welfare offices) statewide that provide TANF, Medicaid, food stamps and other services to low-income clients. Paper surveys, aimed at clients of services and families, were available in Spanish and Portuguese. Clients were asked to complete the surveys and office staff returned them to MCH. The demographic results suggest that by providing both electronic and paper surveys that we succeeded in reaching two different populations, a population of advocates, providers and professionals and a population of clients, families and consumers of Title V services.

On the electronic survey (299 responses): the average age of the respondent was 46; 96% were white; 70% had children under 21; 48% were not employed; 4% had no insurance; 3% had Medicaid; and 82% had employment-based health insurance.

On the paper survey (689 responses): the average age of the respondent was 35; 90% were white; 58% had children under 21; 7% were not employed; 25% had no insurance; 15% had Medicaid; and 26% had employment-based health insurance.

The following were the needs and priorities identified by survey respondents. There were not overall significant differences between groups.

1. Access to health insurance
2. Alcohol and other drug use/misuse
3. Overweight and obesity in youth
4. Access to dental health services
5. Access to mental health services
6. Access to specialty health care
7. Tobacco use in youth and pregnant women
8. Autism
9. Teen suicide
10. Adequate respite care/Asthma (tie)

It is interesting to note, that although it affected a smaller number of families (those with CSHCN) access to adequate respite care was always a paramount concern for those who needed it most.

Surveys provided ample opportunity for narrative comments. Responses that were repeatedly reported included:
- "Insurance for low income moms. Dental for adults"
- "Loss of health care when a child turns 19. There is a huge population of uninsured 19-23 year olds."
- "Teen Depression." "Teen Pregnancy." "Teen Suicide"
- "Disability services for disabled children & ADHD specialists"
- "More awareness of special programs for young moms"
- "Nutrition"

In order to gather more public input, a Town Hall-style meeting was held in November 2009 to help in the prioritization process for the 2010 Needs Assessment. Participants at this meeting included staff from other state agencies, nonprofit organizations, including March of Dimes, New Hampshire Endowment for Health, NH Family Voices, community health centers, health care providers and others. At this meeting, Tricia Tilley, Title V Director, Liz Collins CSHCN Director, and David Laflamme, MCH Epidemiologist, also presented data on identified needs in the three Title V population subgroups, and information from the public input surveys. Participants were asked to rank their top five priorities using a "Pennies for Priorities" method. Each participant received fifteen pennies and a list of the preliminary priorities and was asked to rank their top five priorities. Fifteen baskets, each labeled with a priority area, were placed in the front of the auditorium. Participants were instructed to place 5 pennies in the basket labeled with their highest priority, four in the basket of their next highest priority, three for their third, two for their fourth and one penny for their lowest priority. An extra basket collected participants' written lists of up to three emerging issues that they were aware of in their work.

After the public input from professionals, advocates and families, there was no clear cut ranking across 10 priorities. But what did emerge was the fact that what still matters most to advocates and families is access to:
-Health Insurance
-Mental Health Care
-Substance Abuse/Alcohol Treatment

-Dental Care for Adults and Medicaid Clients
-Respite For Those Who Need It

In addition to public input regarding the Title V system as a whole, input was also gathered about particular systems, including early childhood services and services for children with special health care needs. In 2009, MCH modified a Zero to Three, the National Center for Infants, Toddlers, and Families survey that assessed early childhood health, strong families, positive early learning experiences, and collaboration and system building. In November 2009, SMS, utilized the Champions for Inclusive Communities survey to assess the organization and accessibility of NH's community-based service systems so that family's can easily use them. Each of these information-gathering sessions informed priority setting and directed future planning.

Title V plans to continue to utilize surveys and research the utility of social media of gathering public input, for specific interest areas or population groups in Title V as well as the Title V program as a whole, for future Annual Reports.

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

New Hampshire's 2010 needs assessment process was based on MCHB guidance and best practices. Criteria used to choose top priorities were based on public health principles and included the magnitude of the need; disproportionate effects among population subgroups; problems resulting in significant economic costs; cross-cutting problems that have life span effects; and the feasibility of NH's Title V program to impact the problem. Assessment of Title V capacity was conducted using a modified version of CAST-5.

Process changes since the 2005 needs assessment included a more extensive public input process, as well as a more formal approach for prioritizing needs.

Public Input

Utilizing an on-line and paper survey, input on priority needs was obtained from nearly 1,000 individuals, families, advocates and health care providers. The survey was also available in Spanish and Portuguese and was completed by clients in the state-funded health care agencies and DHHS district offices, enabling the acquisition of input from an often difficult to reach population.

Priority needs

Determining Title V priorities is a complex process that requires weighing multiple factors, including known data, capacity and service gaps, state priorities, and emerging issues. The importance of cultural competence in local and state MCH programs and the need to create supports and enhance services for minority populations seamlessly within the state service system is recognized as a focus for NH's Title V program. Similarly, recognition of the social determinants of health -- poverty, education, and availability of affordable housing, for example -- are seen as guiding themes that are interwoven throughout all priorities and activities. Priorities have been developed that are purposefully broad and systems-focused, and likely to respond to evidence-based interventions.

From extensive research of current state data and an internal and external capacity review, combined with public input, ten priorities emerged that adequately described the needs of the Title V population subgroups of women, infants, families and children with and without special healthcare needs.

1.To improve access to children's mental health services

Public input and data suggest significant mental health needs in children and adolescents and a lack of mental health services and skilled professionals in the State. Suicide is the 2nd leading cause of injury-related death among NH adolescents, and NH's teen suicide rate exceeds the U.S. average. Mental health safety net systems are overtaxed, with long waiting lists.

2.To decrease pediatric overweight and obesity

Obesity is an increasing problem in NH. Available data reveal that over 29% of NH 10-17 year olds were overweight or obese in 2007 (34% of CSHCN), and the numbers are increasing.

Disproportionate obesity rates are observed in those with low socioeconomic status.

3.To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families

New Hampshire's rates of tobacco, alcohol and other substance use and abuse among youth and women are higher than the US rates. Substance abuse treatment capacity continues to be a problem in NH. Smoking during pregnancy can result in low-birth weight infants, pre-term deliveries and infant deaths. Smoking rates are higher among young pregnant women and among those on Medicaid.

4.To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services

The percent of uninsured NH adults in 2009 was the highest in the Northeast and is increasing. Adults who live in rural areas, are young, low income, or members of racial and ethnic minority groups suffer disproportionately. Rising unemployment and reductions to state programs create the potential for decreasing access to care and worsening health indicators among women and children, including CYSHCN.

5.To improve access to standardized developmental screening for young children

Nationally, less than 50% of children with a developmental delay are identified before starting school, impacting readiness to learn. NH has a fragmented system for screening that is ripe for improvement.

6.To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents

Unintentional injuries rank as the leading cause of death for children and adolescents in NH and nationally, killing more in this age group than all diseases combined. Many of these deaths are preventable.

7.To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments

Asthma is the most prevalent chronic condition among children and a leading cause of ED visits for children. Young children are also vulnerable to the effects of lead poisoning. Children with lower SES have poorer outcomes for asthma and are at increased risk for lead poisoning.

8. To improve oral health and access to dental care

Dental care access is a problem in NH, specifically for the poor, under and uninsured. Approximately 44% of NH 3rd grade students experienced tooth decay. Tooth decay was higher and the prevalence of dental sealants was significantly lower in several rural NH counties.

9. To increase family support and access to trained respite and childcare providers

The National Survey of CSHCN and NH state data indicate a lack of adequate respite and childcare services available to this population, including the need for workforce development. A statewide effort is needed to provide support for workforce development to serve CSHCN.

10. To decrease the incidence of preterm birth

Younger mothers and those with Medicaid as a payer source have increased rates of smoking

while pregnant and are at increased risk of premature birth. These findings point to potential intervention areas, such as anti-smoking efforts.
An attachment is included in this section.

III. State Overview

A. Overview

GEOGRAPHY: New Hampshire shares boundaries with Canada to the north, Maine and the Atlantic Ocean to the east, Vermont to the west and Massachusetts to the south. New Hampshire is one of the 3 northern New England states, which along with Maine and Vermont, are more rural than the southern tier: Massachusetts, Connecticut and Rhode Island. According to the State definition of rural, approximately 37% of the population and 84% of the landmass in New Hampshire is considered rural. The majority of New Hampshire towns are considered non-urban or rural, with urban and near urban areas located in the south east and south central regions and primarily rural areas in the western, central and northern sections. The three most urban areas are Manchester, Nashua and Concord, all located in the State's southern tier.

New Hampshire's scenic rivers, mountain ranges, lakes and agricultural lands define the state's culture and geography but also create boundaries and barriers to the resources that improve health. Many New Hampshire residents depend on family and friends to get to and from food shopping, work and community events. Access to oral, mental, primary, specialty and/or reproductive health care can be a significant challenge, whether it's a few blocks or several hours away. The White Mountain National Forest separates the northernmost rural section of the state, which consists of Coos County. Coos County, known as the North Country, has the largest landmass of any county but the smallest population.

DEMOGRAPHICS: New Hampshire has a growing population, estimated at 1,324,575 in 2009, representing a 7% increase since the 2000 census. (1) The population growth rate has slowed over the past two years. (2) While the state's population is still 93.1% white (not-Hispanic), minority populations are steadily increasing. The State's largest racial minority is Asian, representing 1.9% of the population, followed by Black/African American at 1.2%. Hispanics (of all races) make up 2.6% of the population. Most minority populations live in the southern tier of the state. As might be expected based on the differing racial and ethnic proportions in younger age groups, births in NH are also becoming more ethnically and racially diverse. In 2008 and in 2009, over 17% of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only 7.6% of births in 1998. (3)

Although New Hampshire's population is slowly growing, it is also aging. Over 25% of the population is 55 years of age or older. An analysis of the percentage change in population by age group concluded that the 55-74 year old segment of the population will be proportionally larger in New Hampshire than the rest of the nation in 2010. An increase in the overall aging of the population is a trend that influences needs in our communities. Women represent half of the population of the State, and women of childbearing age make up nearly 39% of the total female population and nearly 20% of the total New Hampshire population. The fertility rate in New Hampshire has remained steady, even as the national rate has increased. In 2009, there were 13,683 births in New Hampshire. But there has been a shift in the state as to where those babies are born and this has impacted community services. For a hospital, a low frequency of births makes it both ecomomically unfeasible and limits the quality of services to operate a separate unit with specialized staff and equipment. Due to declining births, two hospitals closed maternity units within the past two years (Weeks Medical Center in Lancaster in 2008, Huggins Hospital in Wolfeboro in 2009). This followed the closing of maternity units by three community hospitals that had occurred between 2002 and 2005 (New London Hospital in 2002, Upper Connecticut Valley Hospital in Colebrook in 2003, and Franklin Regional Hospital in 2005). Currently, there is only one hospital in Coos County (the state's largest county in geographic size) with a maternity unit.

POLITICAL ENVIRONMENT: New Hampshire operates under a unique Governor & Council (G&C) form of government. Five Executive Councilors, each representing 1/5 of the population, are elected separately from the Governor, though for the same two-year term. The Councilors

participate in the active management of the business of the state. Together, the G&C has the authority and responsibility over the administration of the affairs of the state as defined in the New Hampshire Constitution, its' statutes and the advisory opinions of the New Hampshire Supreme Court and the Attorney General. All state departments and agencies must seek approval of both receipt and expenditures of state and federal funds, budgetary transfers within the department and all contracts with a value of $10,000 or more. New Hampshire also has the third largest legislative body in the English-speaking world, consisting of 24 senators and 400 representatives. The structure and size of New Hampshire's executive and legislative branches, respectively, ensure that citizens are well represented in matters of the state. NH's "citizen legislature", so called because each legislator is paid a sum of $100 annually, is historically rooted in a philosophy of limited government and protection of personal privacy.

In January 2005, democratic Governor John Lynch took office, with a platform dedicated to making progress on the issues important to NH families -- education, health care costs, the environment, and employment.

As with many states, New Hampshire is experiencing significant budget challenges as a result of the national economic recession. The DHHS Commissioner, Nicholas Toumpas and Director of DPHS, Dr. Jose Montero, are leading efforts for increased efficiencies in this resource challenged environment. The biennium budgeting process has brought continued fiscal challenges to both the State and DHHS, as New Hampshire strives to achieve balance with the burden of providing services to an aging population in a downward spiraling economy. Almost two thirds of New Hampshire appropriations were for education (including public K-12 and the university system) and health and human services. Public policy debate about changes in the state employee retirement system, the state's Medicaid county-based long term care services for the elderly, and state education funding inevitably have involved conversations about the 'shifting financial burden of public services' from general state taxation to the local property tax. (4)

Budget deficits have been attributed to increasing caseloads in Medicaid, TANF and other human services and decreasing revenues in business and real estate taxes. Trends in Medicaid caseloads far exceeded budget projections and indicate a $1.1 Million shortfall for the elderly and $6.7 Million for non-elderly payments including hospital inpatient and outpatient services, provider payments and pharmacy. In March 2010, there was a 10.1% year over year increase in the number of Medicaid enrollees. Rates have been reduced to providers and controls have been proposed on Medicaid codes for Title V services such as home visiting and child and family health supports.

Similar trends have been seen in TANF. Caseloads have exceeded projections in the State Budget causing deficits. Year to date in SFY2010, there has been a 21% increase in TANF recipients. At this rate, the budget can expect a $2.4 Million shortfall for cash assistance for families.

In addition to increased caseloads, state revenues have been significantly lower than expectation. Without a general sales tax or a personal income tax, New Hampshire's tax revenues rely primarily on two forms of business taxes, the Business Profits Tax and the Business Enterprise Tax. The next highest sources of revenue are the Meals and Rooms Tax and Liquor Sales and Distribution. Currently, all of these revenue sources are below budgeted expectations.

The impacts of the state budget crisis are felt throughout the system. State employees were laid off in October 2009. MCH was impacted by hiring freezes for currently vacant positions (Adolescent Health Coordinator and Prenatal Coordinator) and the Childhood Lead Poisoning Prevention Program (CLPPP) lost state general funding for two environmental lead specialists, as well as funding for its compliance project manager. This reduction of three staff members, along with two federally funded vacancies challenged the CLPPP to re-allot the resources necessary to meet goals and objectives. Adding to these difficult changes was the discontinuation of funding for blood lead testing and paint and dust sampling analyses by New Hampshire's Public Health

Laboratory (PHL), also due to budget reductions in October 2009.

As previously described, Medicaid rates to providers have been reduced and additional controls for cost saving are being explored. Additionally, programs like Home Visiting New Hampshire, that have historically used innovative, collaborative approaches for funding are in jeopardy of ending due to the increased pressure from programs like Medicaid and TANF to focus on their core mission and thus, discontinue support for these joint ventures.

Looking forward, there are no easy answers to reconcile the revenue and expenditure disconnect in New Hampshire. It is clear that social services and health care will continue to be costly to the state General Fund. While perhaps moving the population towards more healthy lifestyles and preventive care in the long run, the federal Patient Protection and Affordable Care Act will have unknown financial impacts to the state in the next five years. Although the federal government will pay for increased Medicaid payments for fee-for-service and for primary care services provided by primary care doctors for 2013 and 2014 the full fiscal impact of expanding Medicaid eligibility is unclear.

SOCIO-ECONOMIC ENVIRONMENT: New Hampshire has an overall median household income significantly above the national average: $68,175 compared to $51,233 nationally. (U.S. Census Bureau, 2007-2008 two-year average). (5) By this estimate, New Hampshire's median household income was the highest in the nation during this period. New Hampshire's 2008 per capita personal income was $3,400 above the national average of $40,208 and ranked eleventh highest among the states. In 2007, per capita income varied widely by county, from a low of $31,179 in northernmost Coos County to a high of $47,196 in Rockingham County, bordering Massachusetts. (6)

Although, New Hampshire is fortunate to boast a high median income, it belies the fact that many families are struggling. Statewide averages often mask differences among subpopulations in the state. The structure of New Hampshire's economy has changed in recent years from one in which a variety of well paying jobs were available, to a "boutique economy" currently, in which good paying jobs are available only to those with high educational levels and skills. The wage disparity has increased between the lowest wage earners and the highest, and the lowest wages have remained stagnant or fallen while the highest have increased, even in a weak economy. Jobs that pay a livable wage are declining, making it more difficult for some families to meet basic needs. (7)

Many occupations and industries have experienced declines in employment during the economic downturn that began in December 2007.New Hampshire's seasonally adjusted unemployment rate eventually hit 7.2 % in September 2009.(8)

The current recession period continues to have a negative impact on the housing market. Housing values have continued to decline. New residential building permits are at historically low levels and the number of foreclosures is at a historically high level. (9) The median gross rent rose for all unit types including utilities from $946 in 2007 to $969 per month in 2008. While rents continued to rise, so did vacancies. New Hampshire's vacancies increased from 4% in 2008 to 5.3 % in 2009. The state's vacancy rate had not exceeded 5% since 1993, during the last recession in New Hampshire. Often an increase in vacancy rates can be attributed to renters moving towards home ownership. Instead, current economic conditions are likely contributing to the recent rise in vacancy rates and increase in insecure housing arrangements for many New Hampshire families. (10)

Homelessness greatly impacts the health and well being of children and youth. Compared to children with homes, homeless children are more likely to have health problems, developmental delays, mental health problems such as anxiety and depression, behavioral problems and lower academic achievement. As much as 12% of the homeless population is estimated to consist of youth between the ages of 16 and 24 years old who are not living in families. Homelessness

creates enormous negative health and social costs for young people. These youth have high poverty rates and are often runaways or throwaways who have experienced physical and/or sexual abuse, childhood homelessness, parental substance abuse, foster care and/or juvenile detention. It is estimated that 25% of foster children have experienced homelessness within 2 to 4 years of leaving foster care. Homeless youth have an increased risk of physical and sexual abuse on the streets and in adult homeless shelters, with sexual assault rates of homeless youth estimated at 15 to 20 percent and physical assault at 50%. Obtaining accurate data on homelessness is challenging; these data often undercount the true population. A one-day count of the homeless in New Hampshire in 2009 found 3,328 single adults; 788 adults in 670 families; and 840 children living in shelters. (11) Other homeless families in New Hampshire often live in seasonal rentals, moving several times per year between campgrounds in the summer and motels and apartments in the winter. Children in these settings are often forced to leave school in the spring when they are must leave a winter rental before the school year ends, disrupting their education and social networks.

Certain demographic and geographic subpopulations in the state experience much higher poverty rates and these disparities have increased over the past decade. Rural residents in New Hampshire experience poverty disproportionately. Gender also is associated with economic inequality. Nearly 22% of New Hampshire families headed by a woman with no husband present had incomes below the poverty level compared to 5.6% of family households overall. (12) This percentage has increased since 2000, when 17.6% of female householder families lived below the poverty level. (13) In 2003, an estimated 19.4% of New Hampshire family households were headed by a woman with no husband present. A higher percentage of women overall (8.4%) live below 100% of poverty compared to men (6.8%).

Children and adolescents are disproportionately affected by poverty, with 9.3% of New Hampshire residents under age 18 living below 100% of the federal poverty level in the previous 12 months, compared to 7.0% of individuals aged 18 to 64 years old and 7.7% of residents aged 65 and older. (14) Poverty and uninsurance among those in late adolescence (18-24 years) is also significantly higher than among other age groups: 16% of youth ages 18-24 (16,000 youth) live in poverty (15) and 30% of adolescents ages 18-24 lack health insurance. (16)

HEALTH CARE ENROLLMENT: New Hampshire is often considered one of the healthiest states in the nation and has one of the highest percentages of residents with health insurance. (17) New Hampshire compares favorably to other states on many indicators of health, ranking among the top five healthiest states between 1995 and 2004. (18,19) Rankings are based on a combination of indicators, including health outcomes, community, environment and health policies.

New Hampshire's strengths include consistently comparing favorably among other states regarding teen birth rates, rates of children under age 18 in poverty, rates of children ages 19-35 months who are fully immunized, infant mortality rates, among others. But statewide averages mask differences among subpopulations in the state. Closer analysis of New Hampshire data, however, reveals statistically significant differences in health behaviors and outcomes, poverty, access to health care and other health and socioeconomic indicators by race, age group and region.

To achieve many of the positive health outcomes, and perhaps also the cause of many of the challenges, an intense amount of private resources and a significant amount of public funds has been invested in health care. Increases in health care costs have been far larger than increases in wages over the last decade. There has also been an increase in the number of uninsured persons, putting an extra burden on the current health care system resulting from uncompensated care. (20) The financial burden is important to consider as health status among all populations.

Medicaid & SCHIP: Healthy Kids Gold (HKG), Medicaid, provides coverage for infants up to

300% of federal poverty level (FPL) and children age 1-18, up to 185% of FPL. Children ages 1 - 18 at 185-400% FPL qualify for Healthy Kids Silver (HKS) with premiums based on income. Effective September 2009, the New Hampshire Healthy Kids program was authorized to expand coverage to young adults ages 19 to 26 years who cannot be included in their family's health insurance plan, and whose incomes are at or below 400% of FPL. Due to budget considerations, and uncertainties of federal health reform, no effective date has been set to implement this expansion.

Pregnant teens to age 19 are eligible for Healthy Kids Gold (<185% FPL) or Silver (186-300% FPL). Pregnant women age 19 and over with incomes up to 185% of FPL are eligible for HKG. Medicaid has been growing as the payer for an increasing number of births in the state. In 2003, Medicaid was the payment source for 20.3% of all births in the state. By 2009, that number has grown to 31%. Of women obtaining prenatal care in MCH-supported community health centers, 68% received Medicaid and 12.8% were self-pay, or uninsured, in 2009. These women are eligible for enhanced prenatal services including social services, nutrition, care coordination and client education provided during a home or clinic visit.

New Hampshire Medicaid has a "Katie-Beckett"-like eligibility pathway called Home Care for Children with Severe Disabilities (HC-CSD). This allows children up to the age of 19 to qualify for Medicaid based on their need for institutional level of care and solely considers the income and resources of the applicant. Currently there are approximately 1750 --1800 children that are covered by Medicaid through this eligibility.

The State's Children's Health Insurance Program (SCHIP) provides health coverage for uninsured children in families with incomes too high to qualify for Medicaid but too low to afford private insurance. New Hampshire's SCHIP is a unique partnership between the NH DHHS and the New Hampshire Healthy Kids Corporation (NHHK). NHHK administers CHIP health insurance programs, outreach and coordination. Enrollment in SCHIP has decreased since 2008, while enrollment in Medicaid, or Healthy Kids Gold has increased. It is assumed that this is directly related to statewide economic indicators.

Strengthening the Safety Net: In response to the need for care to be available to vulnerable and low-income populations throughout the state, Title V partners with community-based and patient-driven health centers and organizations to serve populations with limited access to health care. These populations include low-income families and individuals, the uninsured, those with limited English proficiency and those experiencing homelessness. Many, but not all, of the MCH-funded health centers have received federal health center designations that define their scope of care and reimbursement structure. Fifteen agencies throughout the state provide perinatal care and enabling services such as case management, nutrition counseling, tobacco cessation interventions, and patient-specific social services. Of these, thirteen are considered primary care agencies, offering the full spectrum of health care services to all ages; the other two are ‘categorical' agencies, offering access to reproductive health, prenatal care, and enabling services through various models that meet their community's needs. Eleven agencies provide contracted reproductive health services through Title X funds; six of these are primary care agencies.

In total, Title V-supported comprehensive primary care programs, including community health center and health care for the homeless programs, served 104,622 men, women and children with 477,086 encounters in 2009. Forty-five percent of those served were 185% below poverty. Twenty-four percent of the total patient population was uninsured and 47% received Medicaid, however insurance status is disproportionate among age groups. Children and pregnant women are more likely to receive public insurance and other adults are more likely to be uninsured.

In 2009, the 15 MCH-supported prenatal agencies served 1758 prenatal clients, approximately 13% of NH's pregnant women. Of pregnant women served by MCH agencies, 68% were enrolled in Medicaid for the pregnancy, 12% were uninsured, 14.2% were between 15 and 19 years of

age, and 34.7% were between 20 and 24 years of age. (21) Seventy-six percent of pregnant women receiving care in an MCH-supported agency started care in their first trimester, with agencies ranging in performance from 68% to 85%. Ninety-seven percent received counseling for tobacco cessation, as appropriate, and 89% received screening for substance use. (22)

HEALTH STATUS:

Preconception and Perinatal Health: Title V and Title X, together, are examining the way services are delivered and designed to better incorporate preconception care in order to improve the health of women and couples, before conception of a first or subsequent pregnancy. In doing so, MCH aims to improve health outcomes that include improving birth outcomes and subsequently decreasing unintended pregnancies. New Hampshire has begun work towards the development of a model designed around the ten CDC recommendations aimed at achieving the following four goals: 1) improve the knowledge and attitudes and behaviors of men and women related to preconception health; 2) assure that all women of childbearing age receive preconception care services (i.e., evidence-based risk screening, health promotion, and interventions) that will enable them to enter pregnancy in optimal health; 3) reduce risks indicated by a previous adverse pregnancy outcome through interventions during the interconception period, which can prevent or minimize health problems for a mother and her future children; and 4) reduce the disparities in adverse pregnancy outcomes. The work to date has included the research of best practices, interviews with key programmatic partners (e.g. family planning, home visiting, prenatal, WIC); and initial drafting of a logic model.

This integrated approach is of greater importance as an increasing percentage of New Hampshire births (31% in 2009) are paid by Medicaid, (23) placing a strain on an already weakened system. This compares to 13.4% of the general population of 18-64 year olds in New Hampshire who have Medicaid as their health insurance. (24) With a greater reliance on public insurance on publicly funded health care delivery systems, it is important that programs are well coordinated and integrated to promote optimal health outcomes.

Substance use among pregnant and postpartum women is a serious public health problem in New Hampshire. National survey data consistently show that pregnant women report using tobacco, alcohol and other substances. Early exposure to substance abuse impacts children's life use, dependence, abuse, as well as development, mental health, violence, injury, pregnancy, and infection rates. Screening efforts indicate that 29% of NH prenatal clients report drinking prior to pregnancy. (25) This could result in 8-31 babies born with FAS and 23-92 with FASD annually. (26) Every year, an estimated 703 New Hampshire infants (4.6% of all) are exposed to marijuana and 2,903 (19.0%) are exposed to alcohol during the first trimester of pregnancy.(27)

Smoking during pregnancy accounts for 20-30% of low-birth weight babies, up to 14% of pre-term deliveries and about 10% of all infant deaths. (28) In New Hampshire from 2005-2007, 16% of women smoked during pregnancy. (29) In 2007, 21.7% of New Hampshire women of childbearing age reported smoking, compared to 21.2% of women overall in the U.S. (30) These women are at risk for smoking during pregnancy. Title V works in partnership with the New Hampshire Tobacco Prevention and Control Program to promote evidence based prevention and cessation services for all of those affected by tobacco, especially pregnant women.

Infant Mortality: Nationally and in New Hampshire, the causes of infant mortality, in order of occurrence, are due to: congenital malformations; disorders related to preterm birth and low birthweight; SIDS/SUIDS; effects from maternal complications from pregnancy; complications of the placenta; cord and membranes; unintentional injuries; respiratory distress; bacterial sepsis; neonatal hemorrhage; and other causes. New Hampshire follows the nation with SIDS being the leading cause of death of infants one month to one year of age. New Hampshire routinely ranks favorably when compared to other states. Although in 2006, mortality data slipped to a rate of 6.1/1000 births and New Hampshire ranked 17th, dropping from 1st in the nation the year before. While these comparisons are compelling, they sometimes fail to highlight the hidden complexity

or subtlety of the numbers behind the ranking process. Particular caution should be used when looking at movement year to year in the rate due to the very small numbers of infant death in New Hampshire. Many states are clustered together at the top so there is minimal difference between similarly performing states. More importantly, although each death is tragic for each family, fewer than 100 infant deaths occur per 13,500-14,000 births annually in New Hampshire suggesting that it is more important that we look at trends rather than year by year outcomes alone, given New Hampshire's small numbers. Regardless, this shift prompted policymakers to legislate an Infant Mortality Review that will take effect in July 2010.

Newborn Screening: New Hampshire continues to keep pace with the nation in the fast paced world and science of newborn screening. As of July 1, 2010, screening for Tyrosinemia will be added to the New Hampshire mandated screening panel. Our state screening panel now includes screening for 33 disorders. In addition to program changes among screening panels, programs are evolving their fundamental roles. Other New England states are actively exploring how to implement long term follow up (LTFU) programs within their newborn screening programs. LTFU is a quality assurance component within the newborn screening systems. Monitoring includes case follow-up of basic census data to determine whether individuals identified by newborn screening continue in appropriate care, as well as evaluation of selected outcome indicators in order to evaluate the efficacy of the newborn screening system. In this way, LTFU assists the program in evaluating whether or not the newborn screening system is accomplishing its intended goal of improving health outcomes. New Hampshire has not yet begun this type of long term follow-up at the state level, but is actively engaged in discussions with state and regional partners to better assess the state's capacity to provide this type of service and its potential outcomes and impact.

CSHCN: In New Hampshire, 16.6% of children are considered to have special needs (n= 50,365) compared to 13.9% nationally. (2005-2006 National Survey) There are 21.9% of CSHCN children whose daily activities are affected; 12.6% CSHCN miss 11 or more days of school due to illness. Over two-thirds of families of NH SSI CSHCN surveyed reported that they provide health care for their child at home. Ninety percent of these families engaged in over 11 hours of direct care per week. In addition, half of the families of the SSI CSHCN reported having to cut work hours to care for their child even while experiencing financial distress. Though New Hampshire, in general, (consistent with all of Region I) has high rates of insurance for CSHCN, when compared to the rest of Region I, New Hampshire is ranked lowest for the percentage of CSHCN who were insured for the entire previous year.

Pediatric Obesity: The problem of pediatric obesity in New Hampshire mirrors the national picture. The number of children and adults in New Hampshire who are overweight has increased over the last several years. Of children enrolled in WIC, the percentage of children ages 2 -- 5 years with a BMI at the overweight level was slightly higher (17.8%) than national (16.5%) and the percent with a BMI indicating obesity was approximately the same (14.4% vs. 14.8%). A NH survey of third graders in 81 NH public schools revealed that one in three students (33%) was above a healthy weight and more boys (21%) than girls (15%) were obese. In a chart review of 1,453 children (in the 6-9 year old and the 10-12 year old age groups) receiving health care in 25 NH primary care practices, 32.8% of the children were overweight or obese. MCH will be working with the state's new Obesity Prevention Program, funded by CDC. The program's goal is to prevent and control obesity and other chronic diseases through healthy eating and physical activity targeting the increase of breastfeeding, physical exercise, and fruit and vegetable consumption, and the decrease of sugar sweetened beverage consumption, energy-dense food, and television viewing.

Teen Births: Teen mothers and their children face poorer educational, health, developmental and economic outcomes than their peers who delay childbearing. Repeat teen births compound these problems. The percentage of teen births that are repeat teen births generally mirrors a state's percentage of teen births. Factors associated with repeat births include Hispanic ethnicity and non-Hispanic Black race.(31) New Hampshire's low proportion of minority populations may

account for the low rates of teen births and repeat teen births.

Similar to national rates, New Hampshire's teen birth rate had steadily decreased since 1990, when it was over 30 births/1000 females ages 15-19. In 2003, NH's teen birth rate had declined to 18.1, compared with the US white rate of 27.5 , however an increase to 18.7 percent in 2006 indicates an increasing trend mirroring national data. A decrease in non-marital births occurred across all age groups and was highest among adolescents less than age 20, where 88.1% of births were to single mothers. Three-quarters of New Hampshire's teen births are to 18-19 year olds. In 2005, 11.3% of teen births in New Hampshire were to young women who were already mothers and in 2006 this increased to 13%.

Youth Injury: Unintentional injuries are the leading cause of death for ages 1-24 in New Hampshire . In the time period of 1999 through 2006, there were 527 deaths in ages 1-24 due to unintentional injuries with a rate of 16.31 deaths per 100,000 people in that age category . Nationally, the rate for the same time period and age range was 20.02 deaths per 100,000 so New Hampshire is significantly below that. The rate of unintentional injury deaths increases by approximately 300% between the ages of 14 and 16 . Thus, adolescents are more likely to die by unintentional injuries than are younger children (even though unintentional injuries are still the leading cause of death for children one and above).

Many of these deaths are preventable. The majority of unintentional injury deaths from age 6 to 24 are due to motor vehicle crashes.

Adolescents are the age group with the highest incidence and rate of motor vehicle related death and injury. Although adolescents hold only 7% of the driver licenses in the state of New Hampshire, their death rate due to motor vehicle crashes is substantially higher than any other age group. The risk of motor vehicle crashes is higher among 16- to 19-year-olds than among any other age group. In fact, per mile driven, adolescent drivers ages 16 to 19 are four times more likely than older drivers to crash. In New Hampshire, adolescents accounted for 6.5 percent of the population and 17 percent of the total amount of motor vehicle crashes.

It is interesting to note that adolescents had a higher inpatient discharge rate for injuries due to motor vehicle traffic crashes for adolescents 15 to 17, but lower emergency department visit rate for injuries due to motor vehicle crashes for adolescents 15 to 17, within a five-year period (2001-2005). Adolescents 15-24 have a higher rate of hospitalizations for motor vehicle crashes than any other age group (within this focus age group). In general, emergency medical responders attended to more cases of New Hampshire16-year-olds due to motor vehicle crashes, than any other adolescent age group (2007 and 2008 data). Males were more likely to be hospitalized, while females were more likely to be seen in the emergency department and discharged (2001-2005).

Most of the crashes occurred on local roads, where speed, inexperience, and drug use were contributing factors. Adolescent drivers, just starting out, have several risk factors working against them. First is their inexperience behind the steering wheel. The second is their greater likelihood of engaging in risky driving behaviors such as speeding, driving under the influence, and following other vehicles too closely. New adolescent drivers tend to overestimate their own driving abilities and underestimate the dangers on the road. In 2001-2006, speed was the number one cause of fatal New Hampshire crashes involving 16 and 17 year olds and the majority happened between 9 p.m. and midnight.

Nationally, falls are the leading cause of unintentional injuries among children 0 to 19. They're also responsible for approximately one-quarter of all childhood unintentional injury costs. In New Hampshire, falls are also the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24. The falls rate in New Hampshire was approximately 1,000 hospitalizations/100,000 for ages 0 to 17 (2000-2004) and approximately 12,000 emergency department visits/100,000 for ages 0 to 17 (2000-2004).

Nonfatal fall rates nationally are highest among children ages one to four. In New Hampshire, rates for hospitalizations due to falls (2001-2005) were highest in 15 to 17 year olds among the focus age groups. Rates for emergency department visits (2001-2005) were highest in the zero to four and 10 to 14 age groups.

Emergency department visits due to falls from furniture (beds and chairs were the most common) were a significant issue for children 0 to four years of age in New Hampshire, but gave way to slips and trips and falls with sports equipment from age five on (2000-2006). Within the category of sports equipment, falls from playground equipment occurred the most. Fractures and contusions were the result of most fall related emergency department visits during the same time period (2000-2006).

Oral Health: Improving access to oral health services for vulnerable populations continues to be a high priority for DHHS, but barriers to realizing this goal persist. Data indicate that oral health problems such as dental caries in children and tooth loss in adults are still common in New Hampshire. Effective preventive measures such as water fluoridation and dental sealants are under-utilized; individuals who have lower incomes or less education are substantially more likely to report having dental problems.

Data from the 2009 Healthy Smiles-Healthy Growth Third Grade Survey indicate that statewide the oral health of New Hampshire's children has improved since the first survey conducted in 2001: Caries experience has decreased from 52.0% to 43.6%; untreated decay has decreased from 21.7% to 12.0% and the presence of dental sealants has increased from 45.9% to 60.4%. The 2009 survey also provided the first regional children's oral health data that show marked disparities in oral health by socio-economic status. Children in northern Coos County have significantly higher rates of dental disease and have lower rates of preventive services as their peers in other regions.

Community water fluoridation has long been regarded as the most cost-effective method of preventing dental decay. In addition, it benefits all residents without regard to socioeconomic status. In New Hampshire, only ten communities fluoridate their water. Just one of these municipalities is located in Coos County, while Grafton and Carroll Counties have no fluoridated communities. Since the State's largest city, Manchester, fluoridated its water supply in 1999, it is estimated that approximately 43% of New Hampshire residents have access to fluoridated community water systems.

Title V works in collaboration with the New Hampshire DHHS, DPHS New Hampshire Oral Health Program. Through the Preventive Health and Health Services (PHHS) Block Grant, the DHHS funds school-based preventive programs and community dental centers, some in community health centers or mobile clinics. In 2009, 21 school-based preventive dental programs served 20,262 students in 181 (59%) of New Hampshire schools. Community-based oral health programs provide services using a traditional dental practice model in 14 dental centers across the state. In 2009, 17,104 residents received oral health care through publicly funded dental centers and community-based oral health programs.

Five school-based preventive dental programs serve some of the schools in Coos, Carroll and Grafton counties, and Rochester, New Hampshire, while all public schools are served in Manchester. In the northern regions of the state, where many disparities exist, many schools still do not have sealant programs, largely due to lack of funding. Finding dentists to treat identified children needing treatment is difficult in these same regions because there are fewer dentists, a limited number that take Medicaid children, and even fewer that take uninsured children.

Mental Health: Access to mental health services continues to be a gap in New Hampshire's strained health care infrastructure. While community mental health centers are available, in some regions they are increasingly unable to meet the demand for services. All centers have waiting

lists at some point during each year. In some cases, fees are beyond the reach of low-income families. A primary issue is workforce recruitment and retention for mental health care providers, especially those specializing in care for children particularly young children. One small piece of the solution is the need for increased coordination and integration of behavioral health services. Recognizing this, MCH developed a funding strategy that supports community health centers on a tiered system based upon the level to which they integrate behavioral health. In an ideal, fully integrated system, mental health and primary care providers would share the same sites, the same vision and the same systems in a seamless web of services. Providers and patients would have the same expectations for treatment and all would have access to the same level of care regardless of income or insurance status. However, few organizations have completely achieved that level of integration. Title V and State General Funds have provided funding within each community to move away from fragmented services towards a vision of family centered care, enhanced communication, and aligned systems among providers and patients across the lifespan. Additionally, for CSHCN SMS has leveraged funds to secure psychology and psychiatry consultation for SMS enrollees.

Healthy Housing: As New Hampshire continues to work toward the goal of eliminating childhood lead poisoning as a public health problem, a program shift is under way for the CLPPP to move from a single focus to address multiple environmental, health and safety risk factors affecting families. This strategic planning process involves extensive collaboration between a large and diverse group of statewide experts from the fields of public health, public safety, housing agencies, historic preservation and resources, charitable foundations, the medical community, Community Action Programs (CAPs), Visiting Nurses Associations (VNAs), Community Health Centers, local and state non-profit agencies, as well as the US Centers for Disease Control and Prevention (CDC) and the US Environmental Protection Agency (EPA). Consistent state data is providing a baseline to help structure the Program. The CLPPP maintains an extensive blood lead surveillance system for the purpose of monitoring trends in blood lead levels (BLL) in adults and children in New Hampshire. In 2009, 118 of the 15,051 children tested for lead poisoning had elevated BLLs above or equal to 10 micrograms per deciliter of blood (mcg/dL). The majority of these children (90%) lived in pre-1950 homes and approximately one-third lived in or regularly visited homes built prior to 1978 that had recently undergone renovation. In New Hampshire, approximately 10% of adults and 8% of children currently have asthma, costing the state an estimated $46 million each year. Asthma rates in New Hampshire are higher than the national averages, but similar to those of other New England states. Asthma triggers and lead are present in homes where other health hazards exist, such as radon, tobacco, mold, excess moisture, allergens (i.e., dust mites, mice, and cockroaches), carbon monoxide and other safety hazards.

EDUCATION: On average, New Hampshire is a relatively wealthy, well-educated, small state with pockets of growing diversity. New Hampshire is fortunate to be known for high achieving students; youth generally perform well on standardized tests and compare favorably to other students in other states. Since 2003, eighth graders in NH schools have averaged eight points higher on math and ten points higher on reading than the national average for the National Assessment of Education Programs (NAEP), commonly referred to as the Nation's Report Card. Between 2000 and 2009, college-bound seniors scored consistently higher than the national average on both the reading and math tests. As national scores have declined, New Hampshire scores have risen, widening the gap between NH and the rest of the country. (33)

However, as described throughout this Overview, averages can mask the disparities in vulnerable populations. When children are not served well by our education system, they too often grow to be disconnected young adults who leave school, sometimes too early, without the skills necessary to succeed in the current and emerging array of careers available in the state. In New Hampshire, 9% of 18-24 year olds may be considered disconnected due to their education, incarceration, employment status, poverty and/or familial status. Although New Hampshire was fortunate to have the lowest rate of "out of school unemployed" in 2006 among 16-19 year olds, it is unclear what impact the current economic recession has had on this population of adolescents

and young adults. (34)

One important and early indicator of achievement is the educational level of parents. A child born to a mother who has not completed high school faces increased challenges to school readiness, is at higher risk to drop out of high school, and is more likely to be living in poverty. The good news is that the data for this indicator has improved for the state as a whole. Year after year smaller proportions of children are born to mothers without a high school diploma or GED. On average, 78% of high school freshmen graduate with a high school diploma, 5% more than the national average. Yet, in the poorest communities, 12.2% of the births are to mothers without a high school diploma, compared to the 80% of the rest of the state, that rate is 5.7%. (35)

ACCESS TO CHILD CARE- TANF REDUCTIONS: Learning opportunities that begin in early childhood prepare children for success in school and throughout their lives. A quality early care and education environment can be a foundation for success, but that opportunity is not available to all NH children. Preliminary estimates of the number of families served by the Child Care Development Fund scholarship program were expected to increase from 4900 in 2005 to 5300 in 2009 and the number of children served was expected to increase from 7100 to 7700. However, under the biennium budget restrictions of 2009 and 2010 and due to an increase in the number of families seeking child care assistance through the Child Care Development Fund, DHHS instituted a Child Care Scholarship Wait List in the fall of 2009. In June 2010, there were 2,137 children on a wait list for child care scholarship opportunities.

In addition, the number of child care providers who received scholarship payment for children in their care dropped from 3387 in 2005 to only 2539 providers in 2008. This, combined with the wait list, indicates a reduction in the availability of affordable care for low-income families, which may indicate lower quality care options for young children. In 2009, it was estimated that 30% of eligible children were in unlicensed care.

SUMMARY:

National attention is increasingly being directed to social and economic determinants of health and to developing interventions from a life course perspective, with an understanding of the critical life stages in which to intervene to improve health outcomes. That is to say, health is a developmental process occurring throughout the lifespan. This framework often causes a shift in focus to the early part of the life span, when long-term health programming can be more intense and early childhood development, intuitively allows for interventions that may exact greater returns on resources invested. Sometimes, promoting optimal lifelong health may be best achieved through means other than "traditional" health care interventions. This fits well with the history and culture of Title V that has embraced the need to support a full range of infrastructure, enabling and supportive services in addition to clinical services.

In addition to understanding how a lifecourse perspective may frame the overview and challenges particular to our state, it is also critical to acknowledge how social, ethnic, and demographic changes may also require new priorities and new solutions. The American population, as a whole, is rapidly changing as a result of immigration patterns and significant increases among racially, ethnically, culturally and linguistically diverse populations. State government, community based organizations and systems of care must implement systemic change in order to meet the health needs of a population growing in its diversity. Nowhere are the divisions of race, ethnicity and culture more sharply drawn than in the health of the people in the United States. Although New Hampshire may not be experiencing these demographic changes as dramatically as the rest of the country, our state is still changing in significant ways, especially in the southern and urban areas of our state. Language and differences in cultural practices and beliefs may present potential barriers to care as well as challenges for health care providers. More significantly in New Hampshire, health disparities abound based upon social inequalities such as poverty, socioeconomic status, insurance and employment status.

Each year, as part of the Annual Report, Title V will attempt describe New Hampshire's data as a whole and among socio-economic, racially, ethnically, culturally and linguistically diverse populations in order to examine disparities in health care access and health outcomes. Guided by a belief that health equity will only exist when all residents have the opportunity to attain their full health potential, free from limitations by social or economic position or circumstance, MCH will continue to work towards its mission of improving availability of and access to preventive and primary health care for all children and reproductive health care for all women and their partners, regardless of their income.

Please see attachment for endnotes.

An attachment is included in this section.

B. Agency Capacity

Data from multiple public and private sources reveal that NH has one of the highest quality healthcare systems in the country. Its infrastructure and health outcomes rank favorably compared to the best states. But NH's health care is expensive, and measures of public health and access, by contrast, show opportunities for improvement. Like the state's public health system, in general, the Title V program is limited in scope, but fortunately rich in partnerships and collaborations that serve to promote and protect the health of women, children and families.

New Hampshire's health care delivery system for the Title V population consists of an array of public and private health service providers. This system, which varies regionally, presents special obstacles to the attainment of a seamless system of health care services for all citizens. Much of the state is designated as medically underserved or health professional shortage areas. While NH's two largest cities have public health departments, there is no statewide network of local health departments providing direct health care services. Instead, New Hampshire has built its safety net of health care services on a public private partnership. In 2006, of the 88,184 members enrolled in Medicaid, 34% received care in private office-based settings; 15% in hospital-owned primary care offices; 15% in Dartmouth Hitchcock Clinics; 10% in Federally Qualified Community Health Centers or Look a-likes; 5% in Rural Health Centers; and 21% had no assignment of care.

PREVENTIVE & PRIMARY CARE SERVICES FOR WOMEN, MOTHERS & INFANTS

Aside from population based activities, MCH contracts with community agencies to provide prenatal, reproductive health care, and home visiting services for low income and underserved populations. Fifteen agencies statewide provide prenatal care and enabling services such as case management, nutrition counseling, tobacco cessation interventions, and individual social services. Of these, thirteen are primary care community health centers (CHC), offering the full spectrum of health care services to all ages; the others are ‘categorical', offering access to reproductive health, prenatal care, and enabling services through various models that meet their community's needs. Eleven agencies provide contracted reproductive health services through Title X funds, and 15 agencies provide home visiting services for pregnant women, and mothers and their infants through age one.

Of the thirteen CHCs, eight have Federally Qualified Health Center status. These agencies generally utilize family practice physicians and advanced practice nurses for care provision, and offer full-time service with evening and weekend hours for easy access. Of the two categorical

prenatal agencies, one provides direct clinical care and the other provides a rich assortment of supportive enabling services, such as home visiting, case management, etc. and direct, clinical prenatal care through subcontract with local physicians. All MCH-funded agencies receiving funds for perinatal care must provide, social services, nutritional counseling, and referral for high-risk care.

MCH also contracts with 15 community-based agencies in 18 sites across the state to provide home visiting services for Medicaid eligible pregnant and parenting women. Home Visiting New Hampshire (HVNH) is a preventive program that provides health, education, support and linkages to other community services. These comprehensive, community-integrated programs are evidence based and offer a comprehensive curriculum based on the national Parents As Teacher's early literacy program, and a public health curriculum designed to address, in part, smoking reduction and cessation, maternal depression and family planning. Each family has a team of home visitors that includes a nurse and a parent educator. Parent educators can be highly trained paraprofessionals, or professionals with expertise in social work, family support or early childhood studies. Families are supported in their roles as their child's first and best teacher and learn ways to enhance their child's learning and development.

HVNH served over 900 pregnant women and their infants in SFY09. By funding almost two thirds of program sites in counties with a higher than the state average poverty rates, the program is able reach vulnerable populations. Additionally, HVNH sites are located in a variety of community-based agencies from traditional VNA programs to hospitals, family resource centers to mental health centers. By utilizing a variety of platforms, HVNH can reach families using supports embedded within each unique community.

There are several sources of support for home visiting services and each source of funds is directed towards a different need in the community. Agencies use these funds to provide a comprehensive set of services to families. HVNH supports a public health and family support mission with rigorous performance measures. Comprehensive Family Support is a more flexible primary prevention support available for families. Child and Family Health Support is available to fill gaps to ensure that families' immediate health care needs can be met. Successful agencies coordinate these funding sources within their agencies and communities. DPHS and DCYF have worked together and participated on joint site visits to agencies that receive both sets of funds to ensure coordination. MCH will continue this collaboration with DCYF with new federal funding for Home Visiting in FY2011.

Prenatal Disparities: Section IIIA of this application presents data clearly delineating disparities in prenatal care access and health outcomes for privately insured women versus those uninsured or on Medicaid. Title V -- supported community health centers saw approximately 14% of the state's pregnant women in 2009. Many of these women represent vulnerable populations, because of their low income and other psych-social risk factors including young maternal age, health risks, insecure housing, etc. Because of these factors, they are at increased risk for negative birth outcomes. Therefore, Title V prenatal programs have additional requirements for nutritional support, alcohol. substance abuse and mental health screening, and other enabling services.

The Prenatal Data Linkage Project was formed to link prenatal clinic records and NH birth data to assure that MCH is able to monitor and evaluate MCH prenatal program data. This project has begun to assist in program management, policy development, and evaluation of health services to pregnant women and newborns.

Additional partnerships are needed to support the general population of pregnant women in the state. New legislation was passed in 2010 establishing a Maternal Mortality Review panel. Title V will partner with the Northern New England Perinatal Quality Improvement Network and providers to to conduct comprehensive, multidisciplinary reviews of maternal deaths in New Hampshire. The multi-disiplinary reviews will ultimately result in recommendations for systemic improvements to the perinatal systems in the state.

PREVENTIVE & PRIMARY CARE SERVICES FOR CHILDREN AND ADOLESCENTS

In 2009, the DHHS Office of Medicaid Business and Policy completed the nation's first comparison of children in Medicaid, SCHIP, and commercial plans using administrative eligibility and claims data. Children enrolled in New Hampshire Medicaid and the state's SCHIP program, Healthy Kids Silver, generally do as well or better than their counterparts nationally in accessing and utilizing care. For example, among children aged 3-6 years those using Medicaid 69.9% had a well child visit in 2008; 82.7% of SCHIP; and 77.7% of commercially insured. The NCQA managed care national rate for this age group is 65.3% for Medicaid and 67.8% for Commercial. The children who do not fare as well in routinely accessing care, however, tend to be older children and teens; children in poorer households; and children in Colebrook Franklin, Woodville and Lancaster, which includes some of the most Northern and most remote areas of the state.

Title V's historical responsibility in maintaining Direct and Enabling Services for children has led to the continued clinical oversight and contractual relationships with a statewide network of child health agencies that provide preventive and primary care services. MCH contracts with 14 community agencies throughout the state to provide direct child health care services to low-income, underserved children from birth through age 19. Thirteen of these are the primary care community health centers described above; one is a ‘categorical' pediatric clinic, in the state's largest urban community, which utilizes a multi-disciplinary care model. Strategically focusing efforts on access and support for low-income families, services at the child health direct care agencies include the full spectrum of family practice, such as well-child visits, immunizations, acute care visits and a spectrum of integrated behavioral and oral health services. In 2009, MCH-funded child health direct care agencies saw 17,414 children ages 12 and under, and 10,957 children ages 13-19.

Enabling Services are often the invisible glue that help hold all of the direct health care services together for vulnerable families or families at-risk. Support of these services is also what sets Title V apart from many other public health and government entities. As NH has continued to strengthen the safety net of direct care providers by supporting community health centers with State General Funds, MCH continues to assess its child health resource allocation to assure that low-income children and families have full access to these services and support in using them appropriately.

Since 2000, MCH has had a two-fold approach to child and family health support and home visiting. The purpose of the Child and Family Health Support Services is to promote the health and well being of children ages birth through 18, with priority given to children birth through age ten. These services include assistance with enrollment in health care, referrals, case management and care coordination, education and counseling relative to the child and family, and are most often conducted though home visits.

The evolution of the Child and Family Health Support Services program arose with the blending of categorical "well baby clinics" into newly developed community health centers throughout the state, and the emergence of New Hampshire Healthy Kids - the state's non-profit organization providing access to low cost and free health coverage options for its uninsured children and teens. Although children now had better access to medical care, their parents still needed the education and support services that the "well baby clinic" programs had provided, and needed assistance in enrolling on Healthy Kids, and utilizing the health services.

The range of Child and Family Health Support Services are flexible and specialized to meet the needs of the family. Services are guided by individualized care plans developed following an assessment of the child/family needs by agency staff. In SFY09, 1,205 children received services through the nine contracts at eight agencies via 5,186 home visits, 732 telephone contacts and 588 office encounters, and made 2,062 referrals to a variety of health, dental, and social service

providers. Programs are strategically placed in communities that have disparate need due to geographic access and high proportion of low-income families.

All child health agencies providing direct care and all CHCs screen children for developmental delay and refer them to specialty services as appropriate, though the screening tools used vary widely. In part to address this varied approach to developmental screening, Watch Me Grow, is a new comprehensive screening and referral system for families with children from birth to six years of age. The system is founded on the principles that families are better able to help their young children grow and learn when they have information about their child's health and development; access to screening; and referral to appropriate services.

To further this more unified approach, SMS in collaboration with the NH Pediatric Society hosted two statewide Open Forums on Universal Developmental Screening in 2009 and 2010. Primary care as well as a variety of community based service providers participated in education and discussion about screening recommendations, tools, billing and community supports.

With the release of the revised Bright Futures Guidelines, MCH changed its clinical pediatric and adolescent site visit tool, and is working with the Title V funded agencies to assess the impact of the recommendations, such as any subsequent training needed. The changes in developmental screening and surveillance, including universal autism screening at the 18 and 24-month visits, align with recommendations from a legislative autism commission report issued May 2008. The report of the Commission, of which MCH, representing DPHS, was a member, urges the Department of Health and Human Services to take the lead in providing technical assistance and other supports to ensure that all pediatric primary care settings screen for Autism Spectrum Disorders.

Maps are attached to this Section.

SERVICES FOR CSHCN [Section 505(a)(1)]

REHABILITATION SERVICES FOR BLIND AND DISABLED INDIVIDUALS LESS THAN 16 YEARS OF AGE:

When the results of the 2001 National Survey of Children with Special Health Care Needs (NS CSHCN) were reviewed Special Medical Services determined that there was a need for additional data collection regarding children in NH who were receiving SSI for their own disability. The results from the NS CSHCN survey are meaningful; however, there is a subpopulation of SSI-receiving CSHCN that the national survey was not able to sufficiently capture. SMS completed a follow up survey with the known population of children receiving SSI in NH, the New Hampshire Survey of Parents of Children of Special Health Care Needs Receiving SSI for Their Own Disability, 2004. It was determined that because eligibility for SSI requires both means testing and diagnostic criteria, it was important to have an accurate picture of the needs of this population to guide strategic planning for the Title V program.

The overall results of this survey indicated that this group of children and their families experience an array of health-related difficulties, which may have a more severe impact on the family than the impact of difficulties experienced by families of NH CSHCN in general. The medical and financial eligibility requirements for SSI benefits are sufficiently restrictive to assure that the children receiving Supplemental Security Income for their own disability are, by definition, in a heightened state of need for this assistance. The cost-of-care burden is greater for these families than for the families of NH CSHCN in general. The NH survey also indicated that these children are evidencing a greater need for comprehensive, community-based, care coordination and well-organized service systems. Specific deficits are indicated in the areas of mental health services and the transition to adult services.

Given that the majority of children receiving SSI for their own disability will continue to meet the

financial and medical criteria for this assistance, it appears imperative that New Hampshire's programs for CSHCN specifically and pro-actively address the unique needs of this subpopulation, as they age into adulthood.

In response to this information Special Medical Services has a designated care coordinator to follow-up on all children/youth who are new recipients of SSI. The SMS coordinator provides outreach and support to all new recipients with a medical diagnosis and provides an outreach resource letter for all new recipients with a mental health or developmental diagnosis. In addition, SMS financial assistance for health related needs is available for this population.

The MICE (Multi-Sensory Intervention through Consultation and Education) program is administered by the Parent Information Center in cooperation with the Bureau of Developmental Services to serve children (0-3) for whom there is a concern relative to vision and/or hearing. Children may be referred to the Area Agencies for intake and developmental evaluation, in conjunction with Early Supports and Services (ESS) staff. The emphasis is on the impact of a diagnosed visual/hearing impairment on learning and development. Consultation and technical assistance are provided to ESS teams, and direct services to children and families.

CAPACITY TO PROVIDE FAMILY-CENTERED COMMUNITY-BASED, COORDINATED CARE:

SMS capacity regarding this element is highlighted throughout most of the SMS-specific service and system descriptions, as well as the Needs Assessment. Care Coordination is one of the programs available for children and youth with special health care needs and their families enrolled at Special Medical Services. Community Based Care Coordination for SMS means working together with families and their health care providers, community agencies and schools to help obtain access to needed health care and related services. Following assessment, comprehensive health care plans, responsive to the needs and priorities of the child/family, are developed. Central staff and contractors provide coordination of health related services with other community providers and schools, to ensure continuity of care, and family support. SMS has Care Coordinators available for all regions of the state and services are designed to incorporate home/community visits. All coordinators work with transition age youth to identify strengths and needs and develop a healthcare transition plan. SMS has had a strong focus on supporting the development of care coordination in the medical home by offering expert consultation and support.

CULTURAL COMPETENCE & THE TITLE V PROGRAM:

While New Hampshire's population is still 93.1% white (not-Hispanic), minority populations are steadily increasing. The State's largest racial minority is Asian, representing 1.9% of the population, followed by Black/African American at 1.2%. Hispanics (of all races) make up 2.6% of the population. The vast majority of the state's minority populations live in the southern tier of the state, including the two cities of Manchester and Nashua in Hillsborough County. Approximately 17% of Manchester residents speak a language other than English at home.

Births in New Hampshire are also becoming more ethnically and racially diverse. The percentage of births to racial and ethnic minority groups has more than doubled over the past decade. In 2008 and in 2009, over 17% of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only7.6% of births in 1998.

In addition, New Hampshire has resettled over 6000 refugees since the early 1980's, over 4,800 between 1997 and 2008. The majority of refugees have come from countries in Europe (74% from Bosnia) and Africa (58% from Somalia and Sudan), with smaller populations from Asia and the Middle East. Of the nearly 3000 refugees settled between fiscal years 2002 and 2009, 61% settled in Manchester, 26% in Concord, 8% in Laconia, with smaller populations in other cities and towns. These new residents can experience a range of health and mental health issues including poor nutrition, parasitic infections, communicable diseases and lead poisoning, with

maternal and child health issues predominating.

Achieving cultural competence is more difficult for agencies in rural and non-urban areas where numbers of minorities are smaller. Community-based health agencies are aware of the need for case management, outreach and interpretation services for this population and are working to develop capacity in this area. All SMS contracts for direct or enabling services for CSHCN have had a funded line item for Linguistic/Cultural Needs incorporated. The New Hampshire Endowment for Health reported that provider organizations varied widely in their collection, analysis and use of medical interpretation data. They identified a lack of systematic data collection within healthcare facilities. Providers in Hillsborough County, which includes the state's most diverse communities, serve a much greater proportion of patients with Limited English Proficiency (LEP), about one in seven (14%) patients in those facilities that reported their LEP volume, compared with about 2 percent among the non-Hillsborough providers. Facilities that responded in Nashua reported a third of their encounters (32%) were with LEP patients. The interpreter resources that facilities reported using with the greatest frequency were, in descending order, externally paid interpreters, bilingual clinical staff, bilingual non- clinical staff, and telephone services. Cost and scheduling were significant barriers to facilities in providing consistent, quality services. Providers also identified the difficulty in securing translators for languages less common, including Asian languages, Portuguese, and American Sign Language.

Since mid 2009, a group facilitated by the Asthma Control Program has been meeting to discuss commonalities amongst vulnerable populations and the Division of Public Health's work with them. Meeting monthly, this group has fostered a closer working relationship between MCH and the Office of Minority Health.

Medicaid Client Services provides telephone access in the three languages most spoken by non-native Medicaid consumers, Spanish, Arabic and Bosnian, and all District Offices have mechanisms to facilitate language barrier reduction for their consumers. SMS continues to allocate funds for cultural and linguistic support services for the CHS Child Development, Community Care Coordination and Neuromotor programs. Applications and letters have been translated into Spanish, to better serve the state's Latino population.

In addition to race/ethnicity and language barriers impacting health care access, Title V programs are addressing other issues of cultural competence among MCH populations. These include homelessness, behavioral health, and substance abuse. One issue affecting service availability, accessibility and timely provision, is the lack of comprehensive planning, resource sharing and funding mechanisms, among the state, community-based non-profits, and the private sector. Until recently, health data specific to NH residents was minimal. The MCH and SMS Sections are assessing the new data, to improve health care service and quality, and reduce disparities. SMS has been working on improvements to its electronic data system and as of July 1, 2010 race and ethnicity information will be a formal data set.

The following statutes provide Title V adequate statutory authority to promote and enforce legal requirements as well as assess and monitor MCH status.

NH REVISED STATUTES ANNOTATED (RSA) RELEVANT TO TITLE V

RSA 125, General Provisions, describes the responsibilities of the Department of Health and Human Services' (DHHS) Commissioner to "take cognizance of the interests of health and life among the people". RSA 126 establishes the DHHS to "provide a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety, and well being" of New Hampshire citizens and mandates that services "shall be directed at supporting families, strengthening communities, and developing the independence and self-sufficiency of New Hampshire citizens".

RSA 132, Protection for Maternity and Infancy, provides broad authority for MCH and CSHCN

services "to protect and promote the physical health of women in their childbearing years and their infants and children". It authorizes the Commissioner to: accept federal funds; employ staff; cooperate with federal, state and local agencies to plan and provide services; supervise contracts with local agencies; make rules and to conduct studies as necessary to carry out the provisions of the law. CSHCN services are defined in the law as diagnoses, hospitalization, medical, surgical corrective and other services and care of such children. This law also allows for administration of the WIC program.

RSA 132:10A mandates newborn screening, requiring health care providers attending newborns to test for metabolic disorders. This RSA was amended to clarify wording that allowed funds from the newborn screening filter paper purchases to be used to cover laboratory analysis and related newborn screening program costs. It also deleted the need for the newborn Screening Advisory Committee to have a public hearing before adding any recommended tests to the screening panel.

RSA 132:13 II adopts the definition for Children With Special Health Care Needs as: children who have or are at risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

RSA 611, Medical Examiners, requires the medical examiner to file a record with MCH of any death determined to be the result of result of sudden unexplained infant death.

RSA 137G, Catastrophic Illness Program, defines catastrophic illness to include cancer, hemophilia, end-stage renal disease, spinal cord injury, cystic fibrosis and multiple sclerosis which require extensive treatment such as hospitalization, medication, surgery, therapy or other medical expenses such as transportation. Eligible individuals may have services paid for by DHHS; eligibility and services to be covered are set forth in rules.

RSA 126 contains provisions establishing a division of juvenile justice services; allowing for DHHS quality assurance activities; establishing an Advisory Council on Child Care to plan for improved child care services, report to the Legislature and Governor, and to act as a forum to receive child care related information; the development of primary preventive health services for low-income and uninsured populations; establishing an emergency shelter program, a council for children and adolescents with chronic health conditions and their families, and the Tobacco Use Prevention Funds; and restricts sale of tobacco products to minors.

RSA 126-M:1 recognizes the importance of prevention and early intervention programs and creates a formal network of family resource centers.

RSA 130-A, Lead Poisoning Prevention and Control, provides for public education, comprehensive case management services, an investigation and enforcement program and the establishment of a database on lead poisoning in children.

RSA 135-C allows DHHS to establish, maintain, and coordinate a comprehensive system of mental health services.

RSA 141-C, Immunization, and Reporting Communicable Diseases, prohibits enrollment in school or child care unless immunization standards are met, requires reporting of specified communicable diseases to the State Department of Public Health, prohibits mandatory genetic testing and requires informed consent, except for establishment of paternity and for newborn metabolic screening.

RSA 169-C mandates reporting of suspected child abuse.

RSA 318B:12A allows substance abuse treatment without parental consent at age 12.

RSA 141-C:18 allows adolescents to receive testing and treatment for sexually transmitted diseases without parental consent at age 14.

RSA 265: A prohibits driving while under the influence of alcohol or drugs.

RSA 265:107 A requires the use of child passenger restraints up to age 6 or 55 inches, whichever comes first, and then seat belts in all positions up to age 18 and seat belts up to age 18.

RSA5-C:2 establishes the Division of Vital Records within the Department of State.

RSA 141-J: establishes a statewide, population-based public health surveillance program on birth conditions

RSA 171-A30 allows a voluntary state registry which include a record of all reported cases of autism spectrum disorder (ASD) that occur in NH and other relevant information so as to conduct surveys of ASD

RSA 171-A:32 established a council on autism spectrum disorders to provide leadership in promoting comprehensive and quality education, health care, and services for individuals with autism spectrum disorders and their families.

RSA 254:144:X, Riding on Bicycles, No person less than 16 years of age may operate or ride upon a bicycle on a public way unless he or she wears protective headgear of a type approved by the commissioner of health and human services.

RSA 263:14 outlines a system of graduated licensing for youthful operators.

SB410: establishes a committee to study New Hampshire's rate of infant mortality and develop proposals for remediation. It was signed by the Governor in June 2010.

HB1553: establishes a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in NH. It was signed by the Governor in June 2010.

The full, official text of these statutes may be accessed on the State's website at: www.state.nh.us.

Information on Title V program activities related to these statutes can be found in Sections IIIC, IIIE, and IV of this application.

C. Organizational Structure

NH's Title V Program is located within the New Hampshire Department of Health and Human Services (DHHS). DHHS is headed by Commissioner Nicholas Toumpas reporting directly to Governor John Lynch.

Administration of the Title V Block Grant is assigned jointly to the Maternal and Child Health Section (MCH) for services to women, infants and children and the Special Medical Services Section (SMS) for children with special health care needs (CSHCN). As of July 1, 2010, MCH will resides in the DPHS, Bureau of Population Health and Community Health Services (BPCHS) with population health services such as Chronic Disease and Prevention Programs, and Nutrition and Physical Activity Programs, including WIC.

This re-alignment is focused on linking initiatives and using scarce resources more efficiently through better integration. The overall strategic direction includes:

- Implementation of cross-program integration to increase population-health impact
- Integration of data systems to monitor population-health status
- Strategic use of partnerships to implement population-health approaches
- Focus on chronic disease prevention, diagnosis, treatment and intervention
- Allocation of resources externally to support strategic goals
- Development and implementation a health messaging strategy

SMS resides in the Bureau of Developmental Services, Division of Community Based Care Services. This affiliation aligns services for CSHCN in the same division as other Home and Community Based services for the elderly/disabled adults, individuals with intellectual disabilities and those with mental health issues.

Organizational Charts are attached to visually describe the structure of each program.

Each Title V Program Director (MCH and SMS) is responsible for her own staff, budget, and assuring that activities proposed under the MCH Block Grant are carried out. The MCH Director assumes coordinating responsibilities for the Block Grant submission.

While each program is distinct administratively, they coordinate frequently at the programmatic level. New Hampshire's approach to the 2010 Needs Assessment purposefully incorporated an integration of the MCH and CSHCN populations. This integration began with the planning process and was carried through to the reporting process. References to the Title V population throughout both the Needs Assessment and the annual Block Grant highlight this integration and represent joint evaluations and activities.

THE FEDERAL-STATE BLOCK GRANT PARTNERSHIP:

MCH PROGRAMS

PRIMARY CARE PROGRAM: Using 89% State General Funds and 11% Title V funds, MCH supports thirteen community health centers in providing comprehensive primary care services, including prenatal and pediatric care, for over 104,622 individuals/year. Many sites offer support and enabling services such as nutrition counseling, case management, transportation and interpretation services.

ORAL HEALTH PROGRAM: The Oral Health Program will now be coordinated with MCH in the Bureau of Population Health and Community Health Services. Partnering with Title V to serve all of the Title V populations through direct, enabling and infrastructure services building services, the Oral Health Program serves children and adults through contracted community based services.

PRENATAL PROGRAM: Fifteen local MCH-funded agencies provide prenatal care to over 1700 women/year. Services include: medical care, nutrition, social services, nursing care, case management, home visiting and referral to specialty care.

CHILD HEALTH PROGRAM: Twenty-two community health agencies receive funding to provide child health services. Of these, fourteen are primary care centers that offer direct care to low-income children through clinics and some home visits; eight provide health and social support services to children and their families through a Child and Family Health Support Services grant. All agencies provide case management, outreach, and SCHIP enrollment assistance. In FY09, approximately 17,500 children under age 13 years received primary care services, and over 1,200 children up to age 18, but primarily middle school and younger, received Child and Family Health Support services.

SIDS PROGRAM: The SIDS program offers information, support and resources to families and

care providers of infants who died suddenly and unexpectedly. Information and training are provided upon request. Presentations are made frequently on reducing the risks of SIDS/promoting safe sleep environments to groups such as health care professionals, childcare providers, home visitors, and early childhood education students. The SIDS Program Coordinator has taken a lead role in the state's Child Fatality Review Committee activities, participating in the Executive Committee, chairing the Recommendations Subcommittee, and helping organize and write the bi-annual report. Maternal and Child Health, in collaboration with the Bureau of Behavioral Health and the Office of the Chief Medical Examiner (OCME), developed and sends a grief packet to the families of all children autopsied through the NH OCME, who died from causes other than a sudden unexpected infant death or a suicide.

NEWBORN SCREENING PROGRAM (NSP): The NSP coordinates the screening and short-term follow up of all infants born in New Hampshire for heritable disorders ascertained through dried blood spot testing. As of July 1, 2010, RSA 132:10-a requires that infants be screened at birth for a panel of 33 disorders. The NH panel is in line with other state screening panels within New England and is similar to national recommendations. This statute includes a clause that allows parents or guardians to refuse this screening and also instructs the state to dispose of all specimens within 6 months of collection to ensure privacy.

BIRTH CONDITIONS PROGRAM: In a collaborative effort between Dartmouth Medical School (DMS) and DHHS, NH has maintained a birth conditions surveillance program. Its purpose, in part, is to detect trends in the occurrence of birth conditions. In June 2008, the program was established in law to be under the authority and direction of DHHS. While it will continue to be housed at DMS, an advisory structure monitors the program. MCH will also have new roles in oversight of the "opt out" process for inclusion in the program.

EARLY HEARING DETECTION & INTERVENTION (EHDI): EHDI promotes screening all newborns for hearing loss, and helps assure appropriate follow-up and intervention. In 2009, 97.3% of all infants born in NH hospitals were screened. The program has become well established with its Coordinator, along with the consulting Audiologist, as the mainstay of the tracking and quality assurance activities. The program's Family Advocate works with parents whose infant did not pass the screening to get further testing and other services as needed. Activities are planned to work with the state's lay certified midwives to increase screenings of infants delivered by these non-hospital providers.

ADOLESCENT HEALTH PROGRAM: The Adolescent Health Program promotes adolescent-friendly health care through one adolescent specific clinic, Child Health Services in Manchester and thirteen primary care sites. MCH provides technical assistance regarding adolescent health; participates in population-based activities; and coordinates forums for networking around adolescent issues. ADD ADOLESCENT SEXUAL HEALTH?PRECONCEPTION PROJECT

ABSTINENCE EDUCATION PROGRAM: This program seeks to reduce unintended pregnancies among children ages 10-14 years through community agreements to implement abstinence-only curricula. MCH has awarded Catholic Medical Center (CMC) the Leadership in Abstinence Education Program. In turn, it supports community agencies statewide to provide abstinence education. This program has not been funded since the beginning of State Fiscal Year 10. However, MCH is currently awaiting the new federal funding for abstinence education, approved under health care reform, and will submit a proposal consistent with past strategies (ie, funding the Leadership in Abstinence in Education Program).

HOME VISITING NEW HAMPSHIRE (HVNH): HVNH promotes healthy pregnancies and birth outcomes, safe and nurturing environments for young children, and enhances families' life course and development for pregnant women and families with children up to age one. Eighteen projects currently serve in excess of 1000 families per year. Recognizing the importance of promoting healthy development and improving maternal and child health outcomes, the Affordable Care Act will soon provide funding for a needs assessment and ultimately new programming related to

Maternal, Infant, and Early Childhood Home Visiting Programs in NH. New federal funds will use evidence-based home visiting strategies to help families create a nurturing environment for young children and connect to a range of services including health, early education, early intervention.

HEALTHY CHILD CARE NEW HAMPSHIRE (HCCNH): HCCNH focuses on improving the quality of health and safety in child care environments by increasing the number and expertise of child care health consultants and by incorporating content expertise and collaboration of other state and community programs with the child care industry in NH.

INJURY PREVENTION PROGRAM (IPP): The IPP seeks to reduce morbidity and mortality due to intentional and unintentional injuries. The IPP is also responsible for violence prevention, including sexual assault and domestic violence, funds the State Injury Prevention Center, and is the liaison to the poison control educator associated with the state's Poison Control Center contractor, Northern New England Poison Center of the Maine Medical Center.

STATE SYSTEMS DEVELOPMENT INITIATIVE (SSDI): SSDI is improving data capacity through linking data sets with infant birth and death registries. A major goal is to link birth certificate and NSP data to assure all babies are screened.

TITLE X FAMILY PLANNING PROGRAM (FPP): The FPP provides confidential reproductive health care for low-income women and teens to over 30,000 individuals/year.

CHILDHOOD LEAD POISONING PREVENTION PROGRAM (CLPPP): As of July 1, 2010, the CLPPP will no longer reside within the MCH. The CLPPP is moving toward a more holistic approach to housing, and will become a healthy homes program in the newly formed Healthy Homes and Environments Section within the Bureau of Public Health Protection.

SMS PROGRAMS

Federal funding supports a portion of all sixteen SMS contracts. More specifically, these contracts for direct services are supported 68% with New Hampshire general funds and 32% with Federal Block Grant funds. This Federal-State Partnership includes the following programs:

CHILD DEVELOPMENT PROGRAM: The Child Development Services Network is comprised of five Child Development Programs contracted through DHMC and local community health agencies to provide a community-based multidisciplinary approach to state-of-the-art diagnostic evaluation services, to children (0-6) suspected of or at risk for altered developmental progress.

PEDIATRIC SPECIALTY CLINICS: SMS operates Pediatric Specialty Clinics for Neuromotor Disabilities in 6 locations statewide. These family-centered, community-based, multidisciplinary clinics utilize treatment approaches that encourage parents/children to fully participate in care planning. The clinic coordinator and consultant staff are supported by SMS. The team addresses issues of physical therapy, orthopedics, and developmental pediatrics, with access to SMS nutrition and psychology services.

NUTRITION, FEEDING AND SWALLOWING PROGRAM: The SMS Nutrition, Feeding and Swallowing Program offers community-based consultation and intervention services statewide. Dietitians and feeding & swallowing specialists provide services utilizing a home visiting framework. SMS offers specialized training for all network providers assures a coordinated, outcome-oriented approach that is family-centered and community-based.

FAMILY EDUCATION & SUPPORT SERVICES: Funding received from NH Title V CSHCN supports New Hampshire Family Voices (NHFV) in its mission to assist families with CSHCN. NHFV provides information, support and referral to families with the 800 line provided by SMS. NHFV maintains a comprehensive lending library, specializing in children's books for families and publishes a quarterly newsletter, "Pass It On". NHFV publishes an annual listing of support

group/organizations, and operates a comprehensive website. The staff are parents of CSHCN who can personally relate to the issues and concerns raised by individuals seeking their assistance.

PSYCHIATRY & PSYCHOLOGY CONSULTATION: SMS contracts with both a child psychologist and psychiatrist to provide access and services for CSHCN. Psychology services include statewide information and referral, educational services consultation and education/training to SMS staff as well as partner agencies. Psychiatry services include direct assessment, consultation and short-term condition/medication management while CSHCN are establishing primary care management of their mental health needs.

An attachment is included in this section.

D. Other MCH Capacity

STAFFING

The Maternal and Child Health Section (MCH) is headed by an Administrator, who is the MCH Title V Director and responsible for all MCH activities. MCH employs 20 FTEs (fulltime staff equivalents); 12 positions are paid in some part through Title V funds. The five main programmatic units within MCH include: Child Health and Infant Screening (Child Health, SIDS, EHDI, NSP-- 4 FTEs); Injury Prevention and Adolescent Health (2 FTEs) Women's Health (Family Planning, Preconception Health, 3 FTEs); Data and Decision Management (SSDI, Program Evaluation and Quality Assurance 3 FTEs); Young Families (HVNH, HCCCNH, Perinatal 4 FTEs). All MCH staff are centrally located at the DPHS building in Concord, NH.

The MCH Data Team consists of those staff with an interest or expertise in data collection, analysis and dissemination; the SSDI Program Planner, Program Evaluation Specialist, Quality Assurance Nurse Consultant and contractual MCH Epidemiologist all participate in this team. MCH also employs administrative support staff (6.5 FTEs).

MCH manages three contracts and one MOU to provide specific consulting capacity to MCH. These include: an MOU for OB-GYN medical consultation with Dr Maureen McCanty; contractual relationships for consulting audiologist; pediatric metabolic consultation and an MCH epidemiologist. The audiologist, Mary Jane Sullivan, MA, CCC-A, consults to the EHDI program, bringing experience in pediatric audiology and hospital-based newborn hearing screening programs. MCH epidemiologic support is provided by David LaFlamme, through a contract with the University of New Hampshire's Institute of Health Policy and Practice. Mr. LaFlamme has a PhD from Johns Hopkins University School of Public Health. He devotes three days per week to MCH issues, providing expertise in data analysis and health policy. Dr. Harvey Levy, pediatric metabolic specialist, provides support to medical providers managing clinically significant newborn screening results.

The EHDI Program also has a contractual relationship with the M.I.C.E. (Multisensory Intervention through Consultation and Education) Program of the Parent Information Center to provide parent support, education and advocacy to families of infants who were referred for diagnostic testing or confirmed with a hearing loss.

In addition, MCH houses Jocelyn Vilotti, New Hampshire's health education liaison from the New England Poison Control Center.

The Special Medical Services (SMS) Section is headed by an Administrator, who is the Title V CSHCN Director and responsible for all CSHCN activities. SMS has 18 FTE positions and 16 of them are funded in whole or in part by Title V funds. Some SMS staff due provide Enabling services in addition to the work that contributes to infrastructure building. SMS Care Coordinators have direct caseloads and/or run specialty clinics; 5 coordinators, 1 financial coordinator and 4

support staff work to meet these responsibilities. There is also a Senior state physician who provides direct service to underserved populations and contributes to infrastructure building. There are 4 management level staff (reviewed below) and 1 contract manager. In additon, SMS administers the Partners in Health program, which is funded by the Social Services Block Grant, and the staff for this program include a Program Manager and a Program Assistant.

SENIOR LEVEL MANAGEMENT BIOGRAPHIES: MCH
Patricia M. Tilley, MS Ed, Administrator Ms. Tilley holds a Master of Science in Education from the University of Pennsylvania. She has over 10 years experience in public health in New Hampshire and 15 years experience in education and social services. Previous to becoming Administrator of MCH and Title V Director, she was the Early Childhood Special Projects Director in MCH managing home visiting, Early Childhood Comprehensive Systems, Healthy Child Care NH and other early childhood projects. Prior to state service, she was the Director of a family resource center in rural, western Pennsylvania.

Audrey Knight, MSN, RN, Child Health Nurse Consultant
Ms. Knight has a Masters degree in nursing from Yale University and has held the position of MCH Child Health Nurse Consultant since 1986. She is the SIDS program coordinator and manages the Child Health, SIDS, PSVHSP, NSP and EHDI programs. Ms. Knight has expertise in preventive and primary care for children.

Rhonda Siegel, MS Ed, manages the Prenatal, Injury Prevention, Adolescent Health, and Abstinence programs. She has close to twenty-five years experience in the public health field. With both her undergraduate and graduate degrees from the University of Pennsylvania, Ms. Siegel has worked in the state system for the last
ten years and prior to that was the health educator community outreach coordinator/clinic coordinator for a primary care health center and metropolitan medical center.

Michelle Ricco, BS, Family Planning Program Manager/Title X Director
Ms. Ricco has a BS degree from the University of New Hampshire. Ms. Ricco has 10 years of experience in public health, with an emphasis on program development and management.

Marie Kiely, MS, SSDI Program Planner
Ms. Kiely manages the MCH Data Team and has a Masters degree in Public Health from Tufts University. Ms. Kiely has nearly 20 years of experience in public health programs, including previous management of the New Hampshire Injury Prevention Program and Cancer Registry.

Deirdre Dunn, MS, was hired in October 2008 as the Early Childhood Special Projects Coordinator in MCH managing Home Visiting, Early Childhood Comprehensive Systems, Healthy Child Care NH and other early childhood projects. Ms. Dunn has a MS in Early Childhood Education with a focus on Leadership and Policy, from
Wheelock College and over 20 years experience in community based early childhood programs.

Beverly McGuire, MS, BSN, Quality Assurance Nurse Consultant
Ms. McGuire has a Masters degree in Health Administration and a Juris Doctorate degree. She was hired in 2004 to measure the quality assurance efforts of the funded local agencies. She has 25 years of experience in community health as the CEO of a VNA.

SENIOR LEVEL MANAGEMENT BIOGRAPHIES: SMS

Elizabeth Collins, RN-BC, MS, BSN, BA, Administrator, Title V CSHCN Director
Ms. Collins holds a Master of Science Degree in Nursing from the University of New Hampshire. She had over 20 years working with vulnerable populations in direct care and 3 years working with CSHCN through Title V prior to becoming the Title V CSHCN Director. She has completed the NH LEND program and is ANCC certified in Psychiatric Mental Health Nursing.

Kathy Higgins Cahill, MS, Clinical Program Manager
Ms. Cahill was hired for this position in Dec. 2006. This position manages all statewide care coordination activities including oversight of state and contracted coordinators. She is also the Project Coordinator for SMS' youth transition activities. Ms. Cahill had worked as a part-time staff to SMS for many years, assisting with the formation of the Child Development Program and providing care coordination and clinic management services. Prior to accepting this position she had worked full-time as a Program Specialist.

Margaret Bernard, SMS Data Specialist
Ms. Bernard was hired for this position in 2008. She has excellent skills in database construction, knowledge of the SMS data systems, and expertise in the State Medicaid data systems. Her prior experience includes working for the State Medicaid Service Utilization Review Section and direct service provision for individuals with Behavioral Health issues.

Sharon Kaiser, RN, BS, Early Childhood Systems Specialist.
Ms. Kaiser was hired in Dec. 2006. She has a BS from Keene State College. She has expertise in state systems related to Early Childhood Health and CSHCN. Her previous experience includes statewide Care coordination and prior to that she dedicated herself to residential programming and quality care for children with developmental disabilities. She brings considerable partnership experience with public and private service agencies. She was the Director of a non profit, residential facility for CSHCN for 26 years and a MCH nurse in the community for 7 years.

PARENTS OF CHILDREN WITH SPECIAL NEEDS
New Hampshire Family Voices is supported by Title V funds. This includes funding for three staff who are parents of CSHCN. Martha-Jean Madison (the parent of eight CYSHCN) and Terry Ohlson-Martin (the parent of one CYSHCN) are Co-Directors of the project and Sylvia Pelletier (the parent of two children who are cancer survivors) is the Outreach Coordinator.

STAFFING CHANGES
The most significant staffing change to MCH will take effect July 1, 2010. The entire Childhood Lead Poisoning Prevention Program will move from MCH to a newly organized Bureau of Public Health Protection where it will be re-formed as the Healthy Homes and Environment Section combining Lead Poisoning and Asthma Control. This Bureau will also house the Radiologic Health Section; Food Protection Section and Health Officer Liaison.

Budgetary issues continue to make it challenging to fill positions. Currently, MCH has several vacant positions including its Perinatal Coordinator, Adolescent Health Coordinator and support staff. As new federal funding from the Patient Protection and Affordable Care Act becomes available, it will become more clear how these positions may or may not be filled or funds be leveraged with new opportunities. Currently SMS has one FTE and one 0.5 FTE vacant positions that have been "frozen".

E. State Agency Coordination

New Hampshire's Title V Program has a long history of maximizing limited financial and human resources through the development of partnerships and coalitions. By establishing common goals and objectives in a multitude of collaborative relationships, Title V has greatly expanded its reach throughout the state and within communities. Because of our limited capacity, Title V utilizes its many partners to help us accomplish our priorities.

Coordination of program activities takes place through joint efforts by Title V and others on topics of mutual interest and concern. Community and national health issues and available data drive the investigation, analysis and development of strategies to respond to these concerns.

Partnerships Impacting and Impacted by the Political Environment:

Because of Title V's broad reach and population health approach, Title V staff have been appointed and been invited to participate in numerous executive and legislative-level committees and workgroups including the:

-Brain and Spinal Cord Injury Advisory Council
-Children's Trust Fund
-Coordinated School Health Council
-Council for Children and Adolescents with Chronic Health Conditions
-Mental Health Planning and Advisory Council
-NH Autism Council
-NH Birth Conditions Advisory
-NH Child Care Advisory Council
-NH Child Fatality Review Committee
-NH Childhood Obesity Expert Panel
-NH Children's Advocacy Network
-NH Early Childhood Advisory Council
-NH Early Hearing Detection and Intervention Advisory
-NH Newborn Screening Advisory
-NH Non-Public School Advisory Committee
-NH Teen Driving Committee
-Suicide Prevention Council
-Vital Records Improvement Fund Advisory Committee
-Youth Suicide Prevention Assembly

The role of Title V staff, either as leaders of these groups or active participants, is to provide expertise on the needs of women, children and families and through these partnerships identify and implement cross-cutting activities to help meet priority needs.

During the 2009-2010 legislative session, the NH General Court established the Committee on Committees as a response to the large number of legislatively created Non-Regulatory Boards, Commissions, Councils, Advisories and Task Forces across state government. The charge of the Committee on Committees was to engage in a thorough decision making process to determine which of the committees should remain in effect, be consolidated, or be sunsetted immediately or within one or two years. The rationale for this review and ultimate reduction of committees is part of an overall strategy of the legislature to reduce costs and conserve state agency staff resources.

At the time of publication, it is understood that the Early Hearing Detection and Intervention Advisory will be terminated and it is unclear whether the Newborn Screening Advisory Council will be consolidated with another Advisory Council or maintained as is. It is also unclear which other important legislatively mandated committees will ultimately be affected by these changes. This speaks to the political challenges with which all executive and legislatively-appointed committees, regardless of content area, are occasionally presented.

A positive example of collaboration related to the political environment has been the group effort by an extensive list of stakeholders that led to the subsequent creation of legislatively mandated Autism Council in NH. This effort began in 2001 when the NH Task Force on Autism was created by interested individuals (state and local agencies, private providers and families). They created a report on recommendations for Assessment and Interventions that was widely distributed. This stakeholder group continued to exert political pressure on the need for a more formal response to the considerable impact that Autism Spectrum Disorders (ASD) were having on families, service providers and state agencies. In 2007, the state passed legislation creating a Commission on Autism Spectrum Disorders. The NH Commission on Autism Spectrum Disorders submitted its report on Findings and Recommendations to the legislature in 2008. The legislature and

governor reviewed this report and in 2008 created the NH Council on Autism Spectrum Disorders - to coordinate supports and services for individuals and their families. Title V is well represented in the Autism Council activities as workgroup members and Coordinating Committee chairs.

Partnerships to Support Families and Improve Socio-Economic Environment:

Title V has many collaborative relationships that improve supports for families. The collaborative relationships result in changes in policies, priorities, systems and resource allocation.

In New Hampshire, the Division of Family Assistance (DFA) administers programs and services for eligible residents providing financial, medical and food and nutritional assistance, help with child care costs, and emergency help to obtain and keep safe housing. Child Care Assistance assists parents engaged in work, training or educational activities leading to employment to afford quality care for their children. DFA determines eligibility based on rules and policies administered by the Child Development Bureau.

TANF & Family Planning Program (FPP):
This initiative coordinates FPP and Temporary Assistance for Needy Families (TANF) program efforts. TANF funds are allocated to the Title X Family Planning program within MCH to focus on expanding outreach to target Medicaid-eligible women and teens at risk for pregnancy. Program design was purposefully community-based, developed by family planning and primary care agencies aware of ongoing community efforts and unmet needs.

TANF, Medicaid & Home Visiting New Hampshire (HVNH):
This project supports 19 home visiting programs statewide, including one program with a focus on the state's largest minority and non-English speaking population, with TANF, Medicaid and Title V funds. With MCH as the program administrator, and leveraging TANF funds for base funding and Medicaid support for fee for service reimbursement, HVNH provides health, education, support and linkages to other community services to Medicaid-eligible pregnant women and their families in their homes.

New Hampshire is looking forward to the opportunities that may be available through the Patient Protection and Affordable Care Act to better understand the additional home visitation needs throughout the state and then leverage additional federal resources to enhance the current core HVNH program.

Child Care Scholarship and Redesign:
The MCH ECCS program was a collaborative partner in the process to redesign the NH DHHS Child Care Scholarship Program establishing a more consistent payment to providers, reducing some out-of-pocket cost for families, supporting the inclusion of children with special needs, and encouraging increased quality from providers by creating a tiered Quality Rating System. Enacted in July 2009, this program was suspended in 2010 due to state budget constraints. Even with reductions in payments, a wait list has been developed for child care scholarships that is anticipated to reach more than 3,000 children by July1, 2010.

Division of Children, Youth and Families (DCYF):
DCYF manages protective programs on behalf of NH's children, youth and their families. DCYF staff provide a wide range of family-centered services with the goal of meeting a parent's and a child's needs and strengthening the family system. Coordination with DCYF occurs through several Title V programs and mutual committees. The DCYF Division Director, MCH Child Health Nurse Consultant and SMS Medical Consultant are members of the NH Child Fatality Review Committee, described later in this section, and a representative of DCYF and the MCH Child Health Nurse Consultant are Board Members of the NH Children's Trust Fund. The Family Planning Program Manager is an active member with the Foster Care Health Program Advisory Committee, representing MCH, as are the CSHCN Director and Senior Physician, representing SMS. MCH and SMS are active members of the Watch Me Grow Steering Committee, a group

initiated by the Title V Early Childhood Comprehensive Systems planning process, now working under the mandate of DYCF, under CAPTA and Early Supports and Services, under IDEA, for families to have universal access to developmental screening for young children. Additionally, the SMS senior state physician is now available for monthly consultation to DCYF.

Developmental Disabilities:
SMS is aligned organizationally as a part of the Bureau of Developmental Services (BDS). This affiliation has facilitated a great deal of informal collaboration between Title V and BDS. There have been some joint service efforts as well as overall system cooperation. The CSHCN Director is a member of the BDS Management Team and an SMS representative continues to be an appointee representing Title V on the Interagency Coordinating Committee for Part C. Other joint efforts include participation by SMS on the Council for Children and Adolescents for Chronic Health Conditions and the recent administrative transfer of oversight for the Partners in Health Program. In addition, HVNH has partnered with the Bureau of Developmental Services (BDS) by developing trainings for home visitors across professional disciplines regarding the Emotional Life of Infants and Toddlers. Currently efforts between Title V and the BDS are focused on the statewide initiative, Watch Me Grow, that is planning for statewide implementation of common developmental screening tools and guidelines to be used in a variety of settings.

Lifespan Respite:
Through a grant received by the Administration on Aging, Special Medical Services has initiated the creation of a Lifespan Respite Coalition and workgroups with representatives from the Bureau of Elderly & Adult Services, the Bureau of Behavioral Health, the Bureau of Developmental Services; the Division of Children, Youth & Families, New Hampshire Family Voices, NAMI-NH and Granite State Federation for Families. This initiative is working to create a state registry of respite providers (for all age groups), implementing a competency-based curriculum and completing a pilot program on the impact of the competency-based training.

NH Family Voices:
Title V in NH has a very strong and longstanding collaboration with New Hampshire Family Voices (NHFV), which is also New Hampshire's Family-to-Family Health Information Center. SMS has funded parent consultation, through NHFV, for almost 20 years. In addition to the initial activities of helping families to access services, this role has evolved to incorporate leadership and policy development activities. SMS always seeks input from NHFV when making any kind of Administrative Rule or policy change. NHFV has also participated in discussions with MCH, Medicaid and Child Protective Services regarding rules, services and family needs. NHFV was an active participant in the Needs Assessment Planning Group along with related activities including the CAST-V process and the CSHCN Capacity Assessment.

Partnerships to Improve Health:

Child Fatality Review Committee (CFRC):
The CFRC is charged with reducing preventable child fatalities through systematic multidisciplinary review of child fatalities in NH. The MCH Child Health Nurse Consultant and Injury Prevention Program Manager have played key roles in the CFRC working closely with representatives from the Medical Examiner's Office, DCYF, the state police, and the Attorney General's Office. Title V staff revised the process by which committee recommendations are developed and tracked. Recommendations from the case reviews are often implemented in training provided by the Child Health Nurse Consultant to health, social service, and child care personnel, to reduce the risks of SIDS, promote safer sleeping environments for infants and toddlers, and promote referrals to parenting resources for high-risk families.

State Suicide Prevention Plan Committee:
The Injury Prevention Program and the Adolescent Health Programs collaborate with the DHHS Commissioner's Office, DCYF, and Behavioral Health and other statewide partners on the Suicide Prevention Council Legislated in 2008, the Suicide Prevention Council's mission is to

implement the newly revised State Suicide Prevention Plan. The Injury Prevention Program facilitates the Communications Subcommittee. This committee works on both the communication of suicide prevention issues to the public and educating media on appropriate guidelines for reporting suicide.

The Disparate Populations Group:
Facilitated by the Division of Public Health Services, Bureau of Prevention Services Asthma Program Manager, this collaborative focuses on those sub-populations in the state with distinct health needs. This includes, but is not limited to, those who are incarcerated, the elderly, refugees and immigrants, and minority populations. This collaboration has strengthened the relationship between the Office of Minority Health and MCH. Within the past year, MCH has spearheaded interactive learning sessions with state prison and county jail medical professionals.

Medicaid & Title V:
Title V strengthens the power and reach of Medicaid indirectly through the services Title V directly supports at the local level in community health centers, specialty clinics, family resource centers and through home visits. New Hampshire uses Title V and state general funds for community based agencies to provide outreach, coordination, and referral services. HVNH, a statewide home visiting network leverages TANF funds for base funding for family support, and uses Medicaid fee for service to support health education and as a strategy for EPSDT outreach and informing.

Title V has collaborated on policy and systems building initiatives with the Office of Medicaid Business and Policy to develop and implement local Medicaid codes that pay for Title V-related services, such as child and family support, nutrition and feeding services, and expanded prenatal services. Title V staff have worked in partnership with Medicaid to revise Medicaid Rules and provide training in their appropriate use. Title V and Medicaid have been meeting to readopt a Memorandum of Understanding (MOU), that process has been productive but is currently on hiatus due to constraints related to internal capacity issues.

EPSDT:
The EPSDT Program works with MCH to provide data upon request, clarify program coverage issues, and work with the MCH Child Health Nurse Consultant on committees and workgroups such as the state's Child Fatality Review Committee and SCHIP quality assurance committee. The SMS Senior physician's position supports SMS activities as well as offering significant support to Medicaid including consultation on EPSDT issues, with a particular focus on issues of medical necessity.

Dental:
Medicaid's initiative to increase access to dental care has resulted in most reimbursement rates being raised, a strong partnership with the New Hampshire Dental Society reduced administrative burden of claims processing, ongoing parent and PCP education programs, and improved coordination of oral health programs across the DHHS. The Medicaid initiative focuses on improving access to dental care for underserved populations, such as CSHCN who continue to have limited access to dental care, through provider outreach and education efforts.

CSHCN:
Through a joint venture between Medicaid and SMS, there is a Nurse Care Coordinator position within SMS that is directly responsible for services to CSHCN who are newly enrolled in Medicaid. This coordinator offers outreach and support to all new enrollees in Medicaid through NH's Home Care for Children with Severe Disabilities (HC-CSD). The HC-CSD coordinator represents an ongoing link between Medicaid and Title V. This position has been integral to new rule development for Medicaid related to utilization of services for children qualified under HC-CSD criterion. This individual will continue to offer care coordination and will interface with Medicaid in an ongoing process of identifying children, who are at risk of becoming disqualified for Medicaid under this new rule, and working with their families to develop a modified service

utilization plan.

SCHIP:
MCH collaborates with NH SCHIP and Healthy Kids to disseminate program information and policy changes to local MCH contract agencies, obtain feedback from local agencies to state level programs, and encourage local agencies to enroll all eligible children in SCHIP and Healthy Kids. SMS' care coordinators, providing services statewide, inform uninsured families about the NH Healthy Kids (Medicaid) programs and send applications. A designated care coordinator provides follow-up for families who have applied for SSI but are not receiving Medicaid or enrolled with SMS. This follow-up includes information and applications for SMS and/or Healthy Kids, as requested. The Healthy Kids program coordinator is available for consultation with SMS staff, and refers families as appropriate to NH Family Voices as well as to SMS. The MCH Child Health Nurse Consultant was a member of the SCHIP quality assurance workgroup (QCHIP) and the workgroup overseeing three RWJ-funded ("Covering Kids and Families") pilot projects. MCH staff participated in the proposal review for the SCHIP contract with the Healthy Kids Corporation.

Title X Family Planning Program (FPP):
The New Hampshire Title X program is a major unit within MCH and is administered bythe MCH Director, ensuring a seamless coordination between MCH and reproductive health services. Adolescent Health, IPP, and FPP personnel meet regularly to coordinate activities related to teens. As part of this work, the FPP Manager has spearheaded efforts to develop a plan for Preconception Care for NH. The FPP coordinates with STD/ HIV Prevention and the State Public Health Laboratory (PHL) to implement annual Chlamydia screening and treatment for female FPP clients between ages 15-24. Federal monies for this screening project are for women in the targeted category who would not otherwise be able to afford this screening. Funds are provided to the PHL for testing and to STD/ HIV for treatment.

Adolescent Sexual Health Advisory Board:
Re-organized in 2009, the FPP has taken the leadership of the newly named Adolescent Sexual Health Advisory Board. This workgroup of partners representing Title V, Title X, community partners from across the reproductive health care and adolescent health spectrum have committed to engaging in a strategic planning process to ensure that all adolescents (10-19) and young adults (20-25) have access to quality health care services, as well as, skills, information and supports that promote healthy life choices.

Healthy Homes:
The Childhood Lead Poisoning Prevention Program (CLPPP) has resided within MCH from 2006-2010 and provides surveillance, education, comprehensive case management, investigation and enforcement on lead poisoning in children. As the CLPPP continues to work toward the goal of eliminating childhood lead poisoning, a program shift is under way to move from this single focus to address multiple environmental, health and safety risk factors. CLPPP has formed a Healthy Homes Taskforce that includes other programs within DPHS, Department of Environmental Services, Bureau of Agriculture, Office of Energy and Planning, Community Action Programs, and Department of Safety, Fire Safety Program to create and implement a statewide strategic plan to better integrate services.

Early Childhood Comprehensive Systems (ECCS):
This MCHB-funded initiative is brought together partners from a wide variety of disciplines to develop a statewide plan for early childhood systems. The ECCS partners completed the Comprehensive Plan for Early Childhood Health and Development for NH that is implemented throughout partner agencies and serving in part, as the foundation for the development of the New Hampshire Early Childhood Advisory Council, recently mandated by the Head Start Reauthorization Act. At the cornerstone of ECCS, is Healthy Child Care New Hampshire (HCCNH), a partnership of state agencies and programs that provide health and safety education and support to child care providers. The HCCNH leads the Health and Safety Committee of the Child Care Advisory Council. The HCCNH continues to liaison with DES and child care as they

collaborate on innovative initiatives such as plans for integrated pest management in child care facilities

Rural Health and Primary Care Section (RHPCS):
RHPCS includes the Primary Care Office, the State Office of Rural Health, the Oral Health program and Workforce Development. Access to doctors, dentists, and other healthcare providers is a challenge for residents of some communities in New Hampshire. The mission of these programs is to improve access to healthcare services throughout New Hampshire particularly for those residents without commercial insurance. MCH and the RHPCS work as partners to administer contracts for 13 community health centers that provide primary care, including perinatal care, for low-income families.

WIC:
Title V works with WIC through a mutual knowledge of community agencies and a joint vision of services for women and children. Coordination of immunization, nutrition, breastfeeding promotion, injury prevention and lead screening strategies are shared across programs in both state office and in communities. For example, Title V and WIC staff also jointly participate on the New Hampshire Breast Feeding Task Force which not only meets the mutual goals of improving breastfeeding rates, but serves as an excellent platform for sharing information on a variety of perinatal topics such as co-sleeping, SUIDS risk reduction and newborn screening.

Communicable Disease Control & Surveillance (CDCS):
The mission of CDCS is to monitor communicable diseases in NH. The Surveillance unit maintains the mandatory reportable disease system and is responsible for collecting, analyzing, interpreting and reporting infectious disease data. The Disease Control unit is responsible for infectious disease control activities, case follow-up, patient and provider education and disease outbreak investigation. MCH staff has worked with the Disease Control Program assisting in the state's H1N1 response by participating in clinical advisory groups, disseminating information in a timely manner to key stakeholders, including the local community health centers, and providing nurse staffing to cover routine disease outbreak. Title V continues to participate on workgroups for emergency planning for local response ambulatory care centers.

Data Infrastructure:
Critical to leveraging the infrastructure and capacity of MCH, the DPHS' Health Statistics Section (HSS) is a close partner in developing reports, analyzing data and acting as a technical resource. The MCH Epidemiologist has collaborated with staff in the (HSS) to standardize data.

F. Health Systems Capacity Indicators

Introduction

Health System Capacity Indicators (HSCIs) are helpful in tracking trends in the population and measuring progress toward our health system goals. The HSCIs are also helpful in benchmarking with other states.

The availability of information based on valid, reliable data is an important requirement for the analysis and objective evaluation of the health situation, evidence based decision-making and the development of strategies to promote health among our population. Because of our mandate to collect data regarding these HSCIs, Title V has improved its relationships with other data providers such as Medicaid and Vital Statistics who play a key role in improving data quality throughout the state.

Critical to many of the data improvement activities has been the continuation of the State System Development Initiative (SSDI) grant. SSDI has enhanced the data capacity of New Hampshire's Title V programs by improving existing and establishing new data linkages and surveillance systems. Current linkages between the birth files, perinatal care data files, and newborn

screening data will enable in depth analyses, which identify priority needs for programs and interventions. It has also provided the infrastructure for the MCH Data Team to interface and develop relationships with other data stewards to ensure that MCH has timely access and accurate analysis of other data sources.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	14.7	17.2	17.1	15.5	19.1
Numerator	107	125	126	114	141
Denominator	72789	72789	73500	73548	73650
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data is from the NH Asthma Control Program and is from New Hampshire Inpatient Hospital Discharge Data for 2007. The number does include the number of NH residents hospitalized in border states (ME, MA & VT). For the Denominator Health Statistics created a population table based on US Census and OEP estimates. Here is the citation for this table: Health Statistics and Data Management Section (HSDM), Bureau of Disease Control and Health Statistics (BDCHS), Division of Public Health Services (DPHS), New Hampshire Department of Health and Human Services (DHHS). Population data is based on US Census data apportioned to towns using New Hampshire Office of Economic Planning (OEP) estimates and projections, and further apportioned to age groups and gender using Claritas Corporation estimates and projections to the town, age group, and gender levels. Data adds to US Census data at the county level between 1990 and 2005 but does not add to OEP or Claritas data smaller geographic levels.

Notes - 2008

Data is from the NH Asthma Control Program and is from New Hampshire Inpatient Hospitat Discharge Data for 2006. The number does include the number of NH residents hospitalized in border states (ME, MA & VT). For the Denominator Health Statistics created a population table based on US Census and OEP estimates. Here is the citation for this table: Health Statistics and Data Management Section (HSDM), Bureau of Disease Control and Health Statistics (BDCHS), Division of Public Health Services (DPHS), New Hampshire Department of Health and Human Services (DHHS). Population data is based on US Census data apportioned to towns using New Hampshire Office of Economic Planning (OEP) estimates and projections, and further apportioned to age groups and gender using Claritas Corporation estimates and projections to the town, age group, and gender levels. Data adds to US Census data at the county level between 1990 and 2005 but does not add to OEP or Claritas data smaller geographic levels.

Notes - 2007

Data is from the NH Asthma Control Program and is from New Hampshire Inpatient Hospital Discharge Data for 2005.
It does capture the number of NH residents hospitalized in border states.

Narrative:

STRATEGIES:
MCH staff works closely with the Asthma Program within the DPHS to discuss ways to educate

MCH contract agencies about how to keep children with asthma healthy and how to prevent acute episodes resulting in office, emergency room, and in-patient visits. Housing conditions associated with asthma and other respiratory illnesses include the presence of mold, excess moisture, allergens (i.e., dust mites, mice, and cockroaches) and tobacco smoke.

Nationally, childhood lead poisoning, injuries, and respiratory diseases such as asthma have been linked to substandard housing units. The New Hampshire MCH Section, Childhood Lead Poisoning Prevention Program(CLPPP), in partnership with the National Center for Healthy Housing (NCCH), and stakeholders including MCH-funded primary care, child health and home visiting funded agencies, as well as Community Action Programs, completed the New Hampshire Healthy Homes Statewide Strategic Action Plan in August 2009. The Plan was the first step in identifying health, safety, and quality-of-life issues in the home environment and to act systematically to eliminate or mitigate problems. Implementation of the Plan began in 2010 with the development of a New Hampshire Healthy Homes Steering Committee.

SMS is an active partner with the NH Asthma Control Program. SMS has a representative (Butler) who participates in the NH Asthma Control Program. The NH Asthma Control Program consists of working groups on Health Homes, Schools, Workplaces, Surveillance and Clinical Outcomes. Butler sits on the Asthma Health Improvement subcommittee and the Healthy Homes subcommittee. In addition, all SMS coordinators participated in a training put on by an asthma educator affiliated with the NH Asthma Control Program detailing factors related to the "Control of Environmental Factors that Affect Asthma".

INTEPRETATION:

In NH, approximately 10% of adults and 8% of children currently have asthma, costing an estimated $46 million a year. Asthma rates in NH are higher than the national averages and similar to those of other New England states.

Though the rate (data is for FY 2007) appears to have increased the fact that the overall population is small supports the interpretation that this change is statistically insignificant. When compared using the confidence interval (95% CI: 15.9 - 22.2) the numbers from the last reported year to this one are still fairly consistent.

THe NH Asthma Control staff consider the numbers this year to reflect a natural fluctuation in rates and not a trend in hospitalization rates.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	83.4	84.9	86.1	84.9	88.8
Numerator	4430	4776	4929	4983	5305
Denominator	5312	5628	5722	5869	5975
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data is from the 2009 416 report, via Maria Pliakos (ext. 7194) and Jackie Leone (ext 8169) in the Office of Medicaid Administration.

Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI # 2 and HSCI # 3 are the same.

Notes - 2008
Data is from the 2008 416 report, via Maria Pliakos (ext. 7194) and Jackie Leone (ext 8169) in the Office of Medicaid Administration.

Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI # 2 and HSCI # 3 are the same.

Notes - 2007
Data is from the 2007 416 report, via Maria Pliakos (ext. 7194) and Jackie Leone (ext 8169) in the Office of Medicaid Administration.

Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI # 2 and HSCI # 3 are the same.

Narrative:
STRATEGIES:
Staff of MCH-funded Home Visiting NH agencies work with parents of infants to educate them on the importance of getting preventive care on schedule, and assist with transportation and other issues that may pose obstacles.

MCH reviews charts at its funded primary care agency site visits for adherence to the American Academy of Pediatrics (AAP)/Bright Futures Periodicity schedule for preventive visits and key health screenings. Almost all of the 13 community health agencies and the one pediatric primary care agency will be on, or is in the process of transitioning to, an electronic medical record system which will enhance the agency's ability to assure that children receive the necessary periodic visits on schedule.

Agencies use a variety of techniques such as reminder calls and postcards prior to a visit to enhance compliance, and follow up with phone and letters when a visit is missed. The increase of an electronic medical record system (EMR) that can generate postcards has helped facilitate the process. Infants, with the high number of required immunizations and more frequent acute care visits, tend to have a better show rate than children over one year of age.

Title V recognizes that New Hampshire's investment in its Healthy Kids Program is critical to ensuring that all children have access to preventive health care. MCH and SMS both participate in numerous workgroups to provide leadership and technical assistance for policy makers and program specialists. Title V also participates in the New Hampshire Children's Alliance that creates an annual list of priorities for children. Access to health insurance is always a priority and a critical part of any action steps leading to improved child health and safety.

Community agencies funded for MCH's Child and Family Health Support Services grant are required by their contract's Scope of Services to assure that children referred to their program for services have a primary health care provider/medical home, and they must monitor adherence to the AAP periodicity schedule.

With the community health centers and the eight community agencies receiving Child and Family Health Support Services, community-based organizations will continue their focus on helping families not only to enroll in SCHIP, but to maintain their eligibility and re-enroll without a gap in coverage.

MCH monitors its community health centers and community support programs through the contract agencies' required workplan performance measure of Percent of Eligible Children Enrolled in Medicaid/Healthy Kids Gold. In FY09, the community health centers had an average rate of 84%, with a range of 61--100%. The average rate for the Child and Family Health Support grantees was 95%, with a range of 84--100%.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	83.4	84.9	86.1	84.9	88.8
Numerator	4430	4776	4929	4983	5305
Denominator	5312	5628	5722	5869	5975
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI # 2 and HSCI # 3 are the same.

Notes - 2008
Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI # 2 and HSCI # 3 are the same.

Notes - 2007
Part of NH SCHIP development was Medicaid expansion for infants (0-1), from 185% to 300% of poverty. Therefore the numbers for HSCI # 2 and HSCI # 3 are the same.

Narrative:
DATA SOURCES and CURRENT FINDINGS:
NH Medicaid

As described in the notes, all infants up to 300% of the federal poverty level receive the same SCHIP/Medicaid benefits. Therefore the numerator and denominators for HSCI #2 and #3 are the same.

In 2009, the Office of Medicaid Business and Policy completed the nation's first comparison of children in Medicaid, SCHIP, and commercial plans using administrative eligibility and claims data. Children enrolled in NH Medicaid and the state's SCHIP program, Healthy Kids Silver, generally do as well or better than their counterparts nationally in accessing and utilizing care, despite the fact that national comparison measures are based on managed care programs and New Hampshire Medicaid is fee-for-service. That study, however, is not as helpful in reviewing this particular HSCI as all infants up to 300% of the federal poverty level receive the same SCHIP/Medicaid benefits and because of the methodology of that particular review.

The study revealed that only 2% of infants enrolled in Healthy Kids received zero encounters in

the first 15 months of life.

STRATEGIES:
MCH continues to review charts at its funded primary care agency site visits for adherence to the American Academy of Pediatrics (AAP) Periodicity schedule for preventive visits and key health screenings. Staff of MCH-funded Child and Family Health Care Support and Home Visiting NH agencies work with parents of infants to educate them on the importance of getting preventive care on schedule, and assist with transportation and other issues that may pose obstacles.

Community agencies funded for MCH's Child and Family Health Support Services grant are required by their contract's Scope of Services to assure that children referred to their program for services have a primary health care provider/medical home, and they must monitor adherence to the AAP schedule.

MCH monitors its community health centers and community support programs through the contract agencies' required workplan performance measure of Percent of Eligible Children Enrolled in Medicaid/Healthy Kids Gold. In FY09, the community health centers had an average rate of 84%, with a range of 61--100%. The average rate for the Child and Family Health Support grantees was 95%, with a range of 84--100%.

Agencies use a variety of other techniques such as reminder calls and postcards prior to a visit to enhance compliance, and follow up with phone and letters when a visit is missed. The increase of use of electronic medical record system (EMR) in eleven of the 13 community health centers that generate postcards and facilitate quality assurance activities has also helped facilitate the process. Infants, with the high number of required immunizations and more frequent acute care visits, tend to have a better show rate than children over one year of age.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	81.7	84.0	85.8	85.3	85.3
Numerator	8841	9087	9509	9176	9176
Denominator	10819	10823	11079	10757	10757
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is unavailable. Data from 2008 is used as an estimate.

Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is not collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses. Moreover, this indicator is likely skewed downward for 2005-2007, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is

reasonable to assume that, if the the out-of-state births were included in the data, the indicator for Kotelchuck would be higher.

Notes - 2008
Birth records that did not have information for this measure were not included in the denominator.

Data includes multiple births, and is only for women 15-44.

Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is not collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses. Moreover, this indicator is likely skewed downward for 2005-2007, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is reasonable to assume that, if the the out-of-state births were included in the data, the indicator for Kotelchuck would be higher.

Notes - 2007
1574 birth records did not have information needed to do the necessary computations. These records were therefore not included in the denominator.

Data does not include out-of-state births (unavailable), includes multiple births, and is only for women 15-44.

Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is not collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began by subtracting the date of the last menses. Moreover, this indicator is likely skewed downward for 2005-2007, for the following reason: out-of-state births to NH residents typically have an appropriately high score on the Kotelchuck Index. This is because complicated pregnancies, resulting in high prenatal care usage (i.e. many visits) tend to go to specialty centers outside of NH. In other words, it is reasonable to assume that, if the the out-of-state births were included in the data, the indicator for Kotelchuck would be higher.

Narrative:
DATA LIMITATIONS:

Because many women in New Hampshire with high risk pregnancies seek care in specialty hospitals just over the border in Massachusetts, this measure present unique data quality problems.

New Hampshire continues to experience data limitations related to the irregular state by state implementation of the (national) 2003 revised vital certificate worksheets. Approximately 10% of New Hampshire resident births (and a similar proportion of deaths) occur out-of-state. Our border states have been slower in adopting the latest vital records certificate versions. While some variables can be mapped across versions, others are not comparable. Perhaps the most notable area with this problem is in the timing of prenatal care. We cannot produce accurate statistics related to timing of prenatal care at the population level for a period of several years (ongoing). While we can compute system-level statistics (all events that occur in NH), we know from previous data that the group of New Hampshire residents getting care outside of the state differs in significant ways from the group getting care within the state system.

Notably, the percentage of New Hampshire resident births occurring out-of-state has been decreasing in recent years, perhaps due to the advanced perinatal services that have been

added by some hospitals in southern New Hampshire. Non-resident births occurring in New Hampshire have remained stable.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	74.8	76.4	74.0	74.7	74.8
Numerator	71350	74571	72906	74917	84384
Denominator	95444	97655	98463	100309	112764
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The numerator was provided by Maria Pliakos (ext 7194) and Jackie Leone. Data for the denominator is the sum of two numbers: the number of 1 to 21 year olds enrolled/eligible for Medicaid plus 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. The latter number is uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the two age groups used to determine the denominator do not match exactly, this methodology results in the most accurate estimate available.

Notes - 2008
The numerator was provided by Maria Pliakos (ext 7194) and Jackie Leone. Data for the denominator is the sum of two numbers: the number of 1 to 21 year olds enrolled/eligible for Medicaid plus 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. The latter number is uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the two age groups used to determine the denominator do not match exactly, this methodology results in the most accurate estimate available.

Notes - 2007
The numerator was provided by Maria Pliakos (ext 7194) and Jackie Leone. Data for the denominator is the sum of two numbers: the number of 1 to 21 year olds enrolled/eligible for Medicaid plus 15,157, obtained by Christina Purdam of the DHHS Office of Planning and Research, from the 2001 DHHS Insurance Family Survey. The latter number is uninsured 0-18 year-olds that were eligible for Healthy Kids insurance. Although the two age groups used to determine the denominator do not match exactly, this methodology results in the most accurate estimate available.

Narrative:
In 2009, the DHHS Office of Medicaid Business and Policy completed the nation's first comparison of children in Medicaid, SCHIP, and commercial plans using administrative eligibility and claims data. Children enrolled in New Hampshire Medicaid and the state's SCHIP program, Healthy Kids Silver, generally do as well or better than their counterparts nationally in accessing and utilizing care, despite the fact that national comparison measures are based on managed care programs and New Hampshire Medicaid is fee-for-service.

Claims data suggest that 89% of 16-35 month old Medicaid-enrolled children received at least one preventive care visit in SFY2008 compared to 95% of SCHIP children and 89% of commercially insured children in the same age group. As the children age, the frequency in accessing care decreases across all payer groups and it shifts so that commercially insured, and SCHIP children tend to receive more preventive visits: 55% of 7-11 year old Medicaid-enrolled children received at least one preventive care visit in SFY2008 compared to 63% of SCHIP children and 61% of commercially insured children in the same age group.

The children who do not fare as well in routinely accessing care, however, tend to be older children and teens; children in poorer households; and children in Colebrook, Franklin, Woodsville and Lancaster, which includes some of the most Northern and most remote areas of the state. This is consistent with the disparities in care and access noted in the 2010 Title V Needs Assessment.

It is critically important to understand these disparities among age groups and across different regions in the state in order to develop local, effective strategies to make sure all Medicaid eligible children can appropriately access care.

Outreach efforts are also described in Sections III A and IV E.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	48.1	56.3	57.6	61.7	64.7
Numerator	10057	10230	10545	11418	12782
Denominator	20900	18170	18321	18506	19742
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data is from FY2009 416 report, obtained from Maria Pliakos (ext 7194) and Jackie Leone.

Notes - 2008
Data is from FY2008 416 report, obtained from Maria Pliakos (ext 7194) and Jackie Leone.

Notes - 2007
Data is from FY2007 416 report, obtained from Maria Pliakos (ext 7194) and Jackie Leone.

Narrative:

Strategies:
Since 2005 the percentage of EPSDT eligible children aged 6 through 9 years who have received any dental service has increased. Reasons for the increase include the following:

1-State funded NH school-based oral health programs must include the application of evidence-

based dental sealants billable to Medicaid for 6-9 year old students;

2- From September 2008-June 2009, students in 181 (59%) New Hampshire elementary schools received preventive services including oral health education, screenings, prophylaxis, sealants and fluoride varnish application, and care coordination that linked them with needed restorative treatment in local dental offices;

3- The number of enrolled Medicaid dental providers has increased due to increased reimbursement and streamlined paperwork.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	12.7	8.9	9.5	13.0	12.8
Numerator	193	145	166	243	244
Denominator	1514	1636	1741	1866	1912
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The Denominator is the number of recipients of SSI under age 16 in December 2009 - as reported from the SSA December 2008 report - table titled "Number of children under age 16 receiving federally administered SSI payments. The Numerator utilized was determined by reviewing the total number served by SMS in FY 2009 and determining those children with SSI. There have been continued improvements in the SMS Database and the numerator is the number of unduplicated children served by SMS who had SSI and are <16 by 12/31/2009.

Notes - 2008
The Denominator is the number of recipients of SSI under age 16 in December 2008 - as reported from the SSA December 2008 report - table titled "Number of children under age 16 receiving federally administered SSI payments. The Numerator utilized was determined by reviewing the total number served by SMS in FY 2008 and determining those children with SSI. The SMS database limits our ability to match December 2008 as the cut off date - therefore the numerator was calculated as of the end of the Fiscal Year (June 30,2008). The increase in the percentage served could be related to expanded efforts to outreach to new SSI enrollees as well as improvements in the SMS Database.

Notes - 2007
The numerator is specifically those under the age of 16 as of 12/31/07and the denominator is the number of recipients of SSI as reported from a SSA December 2007 report and a table titled "Number of children under age 16 receiving federally administered SSI payments"

Narrative:
STRATEGIES:

The 2005/2006 National Survey of Children with Special Health Care Needs data for New Hampshire, indicated that only 2.3% of the New Hampshire CSHCN surveyed were receiving

SSI for their own disability, indicating an under-representation of this population in the survey. This same under-representation was seen in the 2001 NS-CSHCN. It is highly likely that this is related to the survey design and the transient nature of this population in NH.

SMS has an outreach program that targets all families of children (with chronic health conditions) newly accepted for SSI. This process incorporates written and telephone contact from a Nurse Care Coordinator to assess the needs of families and to connect them with the appropriate resources, including Special Medical Services.

All new SSI enrollees with a primary medical diagnosis - whether they have Medicaid or not - are now receiving an outreach letter indicating what services SMS might be able to offer them with contact information for our SSI Coordinator. The written outreach letter has also been translated into Spanish to better connect with those who speak Spanish as their primary language. In addition, outreach letters for all new enrolless with a primary mental health or Autism diagnosis, indicating which community and state services and agencies are intended to support their needs.

INTERPRETATION OF DATA:

The rate of children, in New Hampshire , under the age of 16 receiving SSI benefits increased 3% this year. It is possible that the rationale for this could be related to the increasing rate of child poverty but there is also a need to consider a correlation with the significant rate of children being diagnosed with Autism Spectrum Disorders as part of this increase. The percentage of those children being served by Special Medical Services through outreach has also increased. It is possible that SMS' efforts at outreaching to community agencies to make better connections has been successful. In addition the ongoing efforts being made by SMS to outreach to new SSI enrollees has likely played a role in SMS being able to demonstrate consistent numbers for the number of SSI recipients receiving services.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	7.2	5.4	6.5

Narrative:
DATA SOURCES AND CURRENT FINDINGS:
New Hampshire's limited (see notes) low birth weight data is taken from the payment source indicated on birth certificate reports collected by New Hampshire Vital Records.

The 2001 U.S Department of Health and Human Services. Women and Smoking: Report of the Surgeon General stated that smoking during pregnancy accounts for 20 to 30 percent of low-birth weight babies. In NH, 22% of women of reproductive age (18-44) report smoking and 18% of women who gave birth report smoking at any time during their pregnancy. These numbers vary among populations. In 2008, 39% of Medicaid eligible women report smoking during their pregnancy; 36% of pregnant women less than 20 years old report smoking at any time durting their pregnancy.

STRATEGIES:

Because women who are uninsured, under-insured and/or Medicaid eligible often experience disparities in birth outcomes, NH MCH programs focus most strategies to effect low birthweight on these populations. The most significant strategy is in the funding of community health centers and categorical prenatal programs. MCH-funded agencies provide comprehensive prenatal care to low income, uninsured and underinsured women.

Data on initiation of prenatal care and number of visits is collected by and reported to the MCH funded prenatal providers through the Web-based Perinatal Client Data Form (PCDF). Entry to care is a performance measure and allows for analysis of adequacy using entry and visits.

Programatically, MCH is committed to working with partners on collaborative efforts aimed at smoking cessation for pregnant women and all women of reproductive age. Through projects such as the Robert Wood Johnson's Multi-State Learning Collaborative Quality Improvement Learning Teams (QuILT), three teams of community health centers are developing best practices and system changes in promoting all of the 5A's in clinical settings. Notably, teams used their newly acquired PCDF data to form baselines and monitor success. Best practices will be disseminated statewide when the project is completed.

As part of SSDI, the Perinatal Data Linkage Project has continued to move forward. It was formed in coordination with the NH SSDI program to link MCH-funded prenatal clinic records and NH birth data to assure MCH is able to fully understand and respond to the needs of, and threats to, pregnant women and newborns. Additionally, this project will greatly assist in program management, policy development, and evaluation of health services to pregnant women and newborns.

Unfortunately, Title V has been without a prenatal program manager for much of this fiscal year. This has impacted MCH's ability to focus on additional programatic changes or specific data analysis for low birth weight. However, NH continues to work with the March of Dimes to promote educational opportunities for providers in understanding ways to prevent, treat and support low birth weight and premature babies.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	payment source from birth certificate	7.4	2.9	4.1

Notes - 2011
2007 is the most recent data available.

Narrative:
DATA SOURCES AND CURRENT FINDINGS:

The data sources for this indicator come from 2006 New Hampshire Vital Records.

Statistics based on birth certificate data are subject to substantial data issues (completeness, consistency, and small numbers), and therefore, even though it appears that there are reverals in trends, Title V has determined that the data should not solely be used in decision-making until these issues can be resolved.

STRATEGIES:

The New Hampshire infant mortality rate has remained relatively stable over the past several years (though there is some variation primarily due to the small numbers). The number of minority infant deaths in NH is too small to produce reliable single year statistics. The number of years of aggregation required to show the rate would make it difficult to accurately assess temporal trends.

Nationally and in New Hampshire, the causes of infant mortality, in order of occurrence, are due to; congenital malformations: disorders related to preterm birth and low birthweight; Sudden Unexplained Infant Death, effects from maternal complications from pregnancy; complications of the placenta, cord and membranes; unintentional injuries; respiratory distress; bacterial sepsis; neonatal hemorrhage; and other causes. New Hampshire follows the nation with Sudden Infant Death Syndrome (SIDS) being the leading cause of death of infants one month to one year of age.

Although New Hampshire's infant mortality rate compares favorably to other states, as this HSCI indicates, there may be pockets of disparity between socio-economic groups, or like nationally, among other populations such as race or ethnicity. Therefore, legislation was passed in May 2010 establishing a committee to study New Hampshire's rate of infant mortality and to develop proposals for remediation.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	69.9	88.3	82.7

Notes - 2011
Note

Narrative:
DATA SOURCES AND CURRENT FINDINGS:
New Hampshire's entry to care data is collected from the birth certificate reports collected by New Hampshire Vital Records.

STRATEGIES
MCH-funded agencies provide comprehensive prenatal care to low income, uninsured and underinsured women. MCH requires all funded contract agencies to report performance measures related to early entry to care.

MCH and WIC formed a coalition within the DPHS to become outreach partners in a national initiative called Text4Baby. The free health-related text messages for pregnant and newly parenting women reference the importance of early prenatal care and promotes healthy birth outcomes. One example is "For a healthy baby, visit a doctor or midwife early & keep all of your appointments. Hear your baby's heartbeat. See how fast she grows!" New Hampshire's Director of Public Health announced this new social marketing tool during National Public Health Week and a subsequent message was delivered throughout the communities during Women's Health Week.

Coordination and collaboration between health care clinicians and community based support programs.

Site visits to MCH funded agencies include chart audits and discussions on how to improve these strategies and ultimately how to improve outcomes.

The Home Visiting Coordinator will work with the Title X Family Planning Director to investigate how to integrate the Lifecourse Perspective into Family Planning.

The goal of this endeavor will be to increase the number of men and women, who have a reproductive life plan which, will ultimately increase the number of women who enter prenatal care in the fist trimester.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	78.3	88.5	85.3

Narrative:
DATA SOURCES AND CURRENT FINDINGS:
New Hampshire's entry to care data is collected from the birth certificate reports collected by New Hampshire Vital Records.

STRATEGIES:

Because women who are uninsured, under-insured and/or Medicaid eligible often experience disparities in birth outcomes, NH MCH programs focus most strategies to effect low birthweight on these populations. The most significant strategy is in the funding of community health centers and categorical prenatal programs. MCH-funded agencies provide comprehensive prenatal care

to low income, uninsured and underinsured women.

Data on initiation of prenatal care and number of visits is collected by and reported to the MCH funded prenatal providers through the Web-based Perinatal Client Data Form (PCDF). Entry to care is a performance measure and allows for analysis of adequacy using entry and visits.

MCH stresses coordination and collaboration between MCH-funded health care clinicians and community based support programs. One example is the coordination between the Home Visiting New Hampshire (HVNH) program and prenatal providers. The HVNH nurses and home visitors, as part of their education for pregnant women, stress the importance of regular compliance with prenatal care and provide support to overcome potential barriers in accessing care.

Unfortunately, Title V has been without a prenatal program manager for much of this fiscal year. This has impacted MCH's ability to focus on additional programatic changes or specific data analysis for adequacy of care. However, New Hampshire continues to work with the all Title V - supported prenatal providers through site visits, chart audits and technical assistance to ensure that attention is given to early entry to care, retention, and loss to follow-up.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	300
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	300

Narrative:
DATA SOURCES:
This information is available from Medicaid and New Hampshire Healthy Kids.

New Hampshire has one of the lowest percentages of uninsured children. Depending on data sources, the number and rate of uninsured children in the state can vary from a low of 6 percent (21,000 children) per Children's Defense Fund 2008 Fact Sheet , to a high of 9.7 percent (NSCH).

STRATEGIES:

Pregnant women and infants, birth through age one, up to 300% of FPL are eligible for New Hampshire Medicaid and SCHIP.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's**	**YEAR**	**PERCENT OF POVERTY LEVEL**

Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	400

Narrative:
Health insurance is critical for both immediate and long-term implications. With health insurance, children are more likely to have access to a medical home, well child care, immunizations, prescription medications, appropriate care for asthma, and basic dental services. They're also more likely to have fewer avoidable hospitalizations, improved asthma outcomes, and fewer missed days of school. Uninsured children use fewer screening and prevention services and delay care when sick, so when they do enter the medical care system, they're sicker and at more advanced disease stages than the insured. This contributes to higher rate of morbidity and mortality for uninsured both in general and for specific diseases.

New Hampshire has been fortunate, in that its rate of coverage for children has improved over the last decade, partly due to the state's Healthy Kids Program . In 2006, 28% of New Hampshire children ages 0-4 and 22 percent of children ages 5-9 were enrolled in Medicaid. That number has continued to increase, as the economy turned downward. There are still too many children in need of health care coverage, and there is a problem with "churning", which occurs when children are repeatedly dropped and re-enrolled on public programs due to short eligibility periods, lengthy re-enrollment processes, and complex paperwork.

Healthy Kids Buy-In:

Families who are not eligible for Healthy Kids Gold or Silver coverage may be able to purchase the Silver program benefit plan. In addition, children who meet the following criteria may be eligible for the Buy-In program:

-Non-citizen children who are legal residents but otherwise not eligible
-Children ages 19 through 21 still enrolled in high school
-Children who have been uninsured for three consecutive months prior to enrollment

Benefits are the same as the Healthy Kids Silver program. Some co-payments may differ from the Silver program.

Legislation was passed in September 2009, previous to Federal Health Reform, directing the Healthy Kids Corporation to explore expanding this buy-in program to young adults to age 26, but no state general funds were appropriated for the program.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	400

Narrative:
DATA SOURCES:
This information is available from Medicaid and New Hampshire Healthy Kids.

STRATEGIES AND INTERPRETATION:

The Department of Health and Human Services (DHHS) had been preparing to submit a request to the Centers for Medicare and Medicaid Services (CMS) that NH be granted an 1115 demonstration waiver to expand family planning services to a targeted population.

However, once federal health care reform legislation passed, DHHS put waiver request preparation on hold in favor of achieving the service expansion without seeking a waiver. The federal Affordable Care Act, enacted in March 2010 provides states the option to amend their state plans to expand Medicaid funded family planning services. DHHS intends to pursue this option as being more efficient and expedient than the current waiver process. At the time of this report, the Office of Medicaid Business and Policy is anticipating guidance from CMS so that they may pursue a State plan amendment. The current plan is to expand family planning services to a targeted population of women between the ages of 19 and 44 who are post partum from a Medicaid funded birth and women between the ages of 19 and 44 whose incomes are 185% and under.

The primary goal of this waiver is to demonstrate a decrease in annual Medicaid expenditures for prenatal care, delivery, and newborn and infant care by reducing unintended and unwanted pregnancies among an expanded eligibility category of women, and at a later point, men, through the provision of family planning services.

The project proposes to extend Medicaid-funded coverage for family planning services only, to these two eligibility categories: Women between ages 19 and 49 and who are post partum from a Medicaid funded birth; and women between the ages of 19 and 49 whose family income is under 185% FPL.

Once the waiver program has been implemented and is operating successfully, NH plans to "phase-in" coverage of men between the ages of 19 and 65 whose income is under 185% FPL.

Title V and Title X have worked with the NH Office of Medicaid and Buisness Policy to support this waiver and are prepared to work with the provider network to implement it if CMS approves the Demonstration Project.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy**	**Does your MCH program have Direct access to the electronic database for**

	purposes in a timely manner? (Select 1 - 3)	analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2011

Narrative:
DATA SOURCES AND CURRENT FINDINGS

Through the SSDI grant, the MCH is continuing to develop the collaborative relationships to enable access to data from DHHS and other agencies, as well as facilitate linkages between MCH program data and other data sets (e.g. Vital Records). The Section continues to improve linkages between birth certificate and Newborn Hearing Screening Program and Newborn Screening Program data to assure that all newborns are screened for hearing loss and metabolic and other disorders at birth. The system to link birth and Prenatal data is completed and now contains 2.5 years of complete data. MCH has begun analysis of the data and created reports for the contracted prenatal care agencies. MCH staff are continuing to work on enhancements to improve the record linkage rate and other functions to make the system more usable. The Data Mart, which will eventually house all linked MCH data, continues to mature as progress is made in carrying out the linkage plan. Planned expansions of data linkages include adding Childhood Lead Prevention Program (CLPPP), as well as linking Medicaid and WIC data with MCH program data. These linkages will assist the Section in assessing the MCH population and evaluating MCH programs.

A change in leadership of the New Hampshire Division of Vital Records Administration in 2009 resulted in an improved working relationship and significant updates to the dataset. Most notably, the data entry for births to New Hampshire residents occurring out of state is complete through 2008 (2009 is close to complete).

MCH has been improving our internal capacity to link datasets. We have linked a large proportion of maternal hospital discharge records with the birth vital records and are pursuing a similar linkage to discharges for infants.

SSDI funding will enable MCHS to continue to improve access to timely and accurate data for both internal (DHHS) and external users (e.g., MCHS-funded community health centers). Through collaborative efforts with all data stewards and users, MCHS will increase its ability to obtain vital records and Medicaid data for reporting on Title V performance measures and ongoing needs assessment, and increase the ability and skills of project staff to analyze these data routinely. Assignment of 2 highly skilled Office of Information Technology analysts to the data linkages project has moved the project forward over the past 2 years.

New Hampshire's birth conditions surveillance system resides at Dartmouth Medical School (DMS) as a partnership between the NH DHHS Title V program and DMS. Data is used to detect trends in the occurrence of birth conditions; evaluate the need for and facilitate access to supportive health services; guide and assess the progress of statewide prevention activities; and educate the community, health care providers and service agencies regarding birth conditions. Participation is voluntary.

New Hampshire does not receive CDC funding for or participate in PRAMS.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
NH Youth Tobacco Survey	3	Yes
Behavioral Risk Factor Surveillance Survey	3	Yes

Notes - 2011

Narrative:
DATA SOURCE: 2009 NH Youth Risk Behavior Survey Results

OTHER INFLUENCING DATA:

According to the NH TOBACCO PREVENTION AND CONTROL PROGRAM's 2007-2009 Youth Tobacco Survey, the Centers for Disease Control and Prevention (CDC) estimates that 31,000 youth under 18 years of age now alive in New Hampshire will ultimately die prematurely from smoking and tobacco related diseases, such as lung cancer, cardiovascular diseases, and respiratory diseases.

More promising however, is that the smoking prevalence for NH high school students has significantly declined from 25.3% in 2001 to 16% in 2009. NH has met its national health objective for 2010, which is to reduce the prevalence of current cigarette use among high school students to 16%.

In 2009, the Youth Risk Behavior Survey (YRBS) revealed that:

10.4% of the students smoked a whole cigarette for the first time before age 13 years.
Of those 10.4%, 11.0% were males; 9.8% were females.

20.8% of the students smoked cigarettes on one or more of the past 30 days.
Of those 20.8%, 21.6% were males; 20.0% were females.

9.5% of the students smoked cigarettes on 20 or more of the past 30 days.
Of those 9.5%, 9.2% were males; 9.6% were females.

8.4% of the students used chewing tobacco, snuff, or dip on one or more of the past 30 days.
Of those 8.4%, 13.8% were males; 2.6% were females.

16.1% of students smoked cigars, cigarillos, or little cigars on one or more of the past 30 days.
Of those 16.1%, 22.1% were males; 9.7% were females.

28.9% of the students smoked cigarettes or cigars or used chewing tobacco, snuff, or dip on one or more of the past 30 days.
Of those 28.9%, 33.8% were males; 23.8% were females.

STRATEGIES:

In order to address smoking among youth, it is important to address environmental access. In New Hampshire, state law prohibits selling or otherwise furnishing tobacco to a person under 18 years of age (RSA 126-K: 4). NH law also prohibits the sale of loose cigarettes. The NH Tobacco Prevention and Control Program's 2007-2009 Youth Tobacco Survey asked current youth smokers in high school how they usually got their own cigarettes during the 30 days. Across all grades, students reported that they did not usually buy their own cigarettes. Most currently smoking high school students said that they usually got their cigarettes by giving someone else money to buy them or by borrowing or "bumming" them. Of those much smaller number of current youth smokers who purchased their own cigarettes, 28% bought them in a convenience store and 38% in a gas station. This points to an opportunity for increased education of store clerks and enhanced enforcement, as well as a larger social marketing efforts aimed at young adults to reduce the practice of buying for teens.

IV. Priorities, Performance and Program Activities

A. Background and Overview

New Hampshire recognizes that the needs assessment process is continuous. Data and public input about our programs, populations and maternal and child health issues must be systematically reviewed annually. Results from the 2010 Statewide Needs Assessment, state and national performance measures, health systems and capacity indicators, public comment and community stakeholders provided an even richer, more comprehensive picture of the Title V needs and capacities in our state. Together, the priorities represent each of the four levels of the MCH pyramid and all MCH population groups.

State government, community based organizations and systems of care must implement systemic change in order to make substantive improvements for the Title V population. To affect needed change, Title V must select among many possible priorities. This is a complex process that requires weighing multiple factors, including known data, capacity and service gaps, state priorities, and emerging issues. In the past decade, NH's Title V planning and prioritization process has become stronger, more structured and much more deliberate in order to meet the health needs of a population growing in its diversity. It is imperative to continue to methodically move towards reducing health disparities and enhance the cultural competency of local and state MCH programs. Similarly, recognition of other social determinants influencing health outcomes -- poverty, education, and availability of affordable housing, for example -- are seen as guiding themes that are interwoven throughout all priorities and activities. Priorities and State Performance Measures (SPM) have been developed that are purposefully broad and systems-focused, and likely to respond to evidence-based interventions.

SPM 1: The rate of psychotherapy visits for adolescents ages 12-18 years, with a diagnosed mental health disorder.
Addresses Priority 1: To improve access to children's mental health services.
.
SPM 2: Percent of 3rd grade children who are overweight or obese.
Addresses Priority 2: To decrease pediatric overweight and obesity

SPM 3: Percent of 18-25 year olds reporting binge alcohol use in past month.
Addresses Priority 3: To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.

SPM 4: Percent of Community Health Centers providing on-site behavioral health services.
Addresses Priority 4: To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services.

SPM 5: The percent of parents who self-report that they completed a standardized, validated screening tool used to identify children at risk for developmental, behavioral or social delays.
Addresses Priority 5: To improve access to standardized developmental screening for young children.

SPM 6: The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant/driver in a motor vehicle crash
Addresses Priority 6: To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents.

SPM 7: The percent of households identified with environmental risks that receive healthy homes assessments.
Addresses Priority 7: To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments.

SPM 8: Percent of New Hampshire communities with fluoridated water systems that fluoridate within the optimal range.
Addresses Priority 8: To improve oral health and access to dental care.

SPM 9: The percent of families with children/youth diagnosed with severe emotional disturbance, moving into permanency placement through DCYF, who have access to a trained respite provider for up to 50 hours during the first year of placement.
Addresses Priority 9: To increase family support and access to trained respite and childcare providers.

SPM 10: The percent of preterm births to mothers who reported smoking before pregnancy.
Addresses Priority 10: To decrease the incidence of preterm birth.

Once priorities are set and the appropriate metrics for evaluation are assigned, it is critical that strategies and interventions are aligned with existing Title V capacities and leveraged with collaborative partnerships.

Once priorities are set and the appropriate metrics for evaluation are assigned, it is critical that strategies and interventions are aligned with existing Title V capacities and leveraged with collaborative partnerships.

For example, children and youth from low-income families are at an increased risk for mental health disorders and in NH, the Medicaid population presents with twice the service use prevalence for mental health services compared to privately insured children. In rural areas, the prevalence of children with mental disorders is similar to that in urban areas, but there are increased barriers to care, resulting in delayed treatment. There are additional significant geographic disparities in capacity. The northernmost counties do not have the mental health workforce, especially those who are trained to meet the needs of children. Community health centers, among other providers, are left to try, at best, innovative and integrated methods to address growing needs. Therefore, to measure access to service, Title V will measure the rate at which adolescents on Medicaid with a documented mental health disorder have a documented annual psychotherapy visit. This measure, also used by the NH Office of Medicaid Business and Policy, will help us better understand whether or not adolescents are receiving appropriate care. Further analysis will allow us to look for regional disparities.

Several of NH's priorities and performance measures lend themselves to collaborative and integrated interventions. Title V will utilize strategies like Text4Baby, a mobile phone-based health promotion program, while developing new partnerships to build infrastructure and strengthen enabling services. By measuring smoking prevalence rates, NH will maintain focus on one area where our state does not compare as favorably when compared to other states. Through continued multi-pronged efforts like social media messages to quality improvement efforts to increase adherence to the 5 A's, Title V ultimately hopes to impact the rate of preterm birth.

Annual report accomplishments, current activities, and planned activities for each of the 18 National Performance Measures and other outcome measures and indicators are discussed in the following sections.

B. State Priorities

STATE PRIORITIES

The New Hampshire Title V Needs Assessment is intended to be a living document that will inform stakeholders and community partners and focus the direction of program design and resource allocation. It is anticipated that the activities described below will be modified as they are continuously evaluated.

To improve access to children's mental health services

Access to mental health services continues to be an identified need in New Hampshire, and the need for these services is great. An estimated 20% of New Hampshire children aged 5-19 have a diagnosed mental disorder, 3-5% of children are estimated to have attention disorder and 0.7% were diagnosed with an autism spectrum disorder. Mental and behavioral health disorders can impact a child's emotional, intellectual, and behavioral development and can hinder proper family and social relationships. Treatment capacity for mental health issues is limited in the state, and concerns about cost are a considerable barrier for families seeking care, regardless of insurance status.

Because of these needs, activities in the following year will include: maintenance of community health center (CHC) funding that provides incentives for increased integration of behavioral health services in primary care; education of CHC staff about use of validated screening tools for specific MCH populations including early childhood, adolescence and perinatal period; partnerships with experts in psychopharmacology to provide training to CHCs; statewide collaborative activities on perinatal depression; and recommendations for statewide systems improvements in Maternal Mortality Review

Strategies for CHYSCN include: exploration of using Title V/CSHCN funds to create psychiatrist consultation available for primary care providers for children managing psychiatric medications and participation in DHHS evaluation of feasibility of an In-Home Supports Waiver for children with diagnosed mental health disorders.

To decrease pediatric overweight and obesity.

Obesity in children and adolescents in the United States of America has become a critical health problem with enormous health and economic costs. More than 29% of NH school aged children are overweight or obese. There are disproportionate effects among low-income families, families of certain ethnic groups and families where there is parental obesity. Children living in poverty in less educated families as well as children of Hispanic and African American background are more likely to be overweight.

Title V will take an integrated approach to address this issue that has life course and population health ramifications. Strategies will include: increased breastfeeding training for providers; education of CHCs about recommended protocols to follow when BMI is > 85 percentile; education and strategies about family engagement and how to talk to parents about overweight/obesity issues ensuring all eligible families are enrolled in WIC. SMS coordinators will document the BMI of children with special health care needs newly enrolled in the Care Coordination program upon receipt of primary care records and identify appropriate referrals for those overweight or obese children. All children in the Neuromotor clinic will have their BMI assessed at clinic visits and identify appropriate referrals for those overweight or obese children. Both SMS and MCH staff will continue participation in I Am Moving, I Am Learning trainings for childcare providers. Additionally, technical assistance from the Region I Knowledge to Practice resource will focus on understanding the lifecourse implications and strategies for including CSHCN into statewide overweight and obesity initiatives. This is scheduled for the Fall 2010 with expert assistance for Boston University.

To decrease the use and abuse of alcohol, tobacco and other substances among youth, pregnant women and families.

Smoking during pregnancy accounts for 20-30% of low-birth weight babies, up to 14% of pre-term deliveries and about 10% of all infant deaths. In NH in 2007, 21.7% of women of childbearing age smoking, compared to 21.2% of women overall in the U.S. YRBS data reveals that 45% of NH high school students had an alcoholic drink in the past 30 days and 28% participated in binge

drinking. Over 50% of NH young adults 18-25 participate in binge drinking.

Because of the cross cutting health and social needs related to tobacco, alcohol and substance abuse, the following strategies are being implemented: CHCs will use validated screening tools for specific MCH populations including adolescence and perinatal period; innovative collaborations, such as the home visiting partnership with Child and Family Services, to provide home --based TWEAK assessment for and referrals to treatment to alcohol abusing pregnant women; social media messaging with high school students combining binge drinking and sexual violence messages. MCH will continue partnerships to address smoking cessation activities with specific MCH populations including youth, adolescents and pregnant women.

To improve the availability of adequate insurance and access to health care and maintain the infrastructure of safety net providers/services

Uninsured children are at higher risk for negative long-term effects on health and economic productivity than insured children.(9) The uninsured use fewer screening and prevention services and delay care when sick, so when they do enter the medical care system, they tend to be sicker and at more advanced disease stages than the insured. This contributes to higher rate of morbidity and mortality for uninsured both in general and for specific diseases.(11) Although NH compares favorably to the U.S. for rates of uninsured children, there are age and income disparities.

Title V staff will continue to work with Community Health Center staff as they track/monitor when children's Medicaid coverage is about to lapse in order to decrease "churning" increasing retention and improving "re-determination" rates. MCH will continue to monitor performance measures of direct and enabling services, which ensure that all eligible children are continuously enrolled. NH Family Voices and SMS staff provides assistance via phone and mail out packets regarding what to bring to the District DFA Office when applying for TANF and HKG, including HC-CSD. At the state systems level, Title V staff will continue to collaborate with SCHIP and Medicaid staff on state/local level on initiatives.

Beyond simply having access to an insurance product as a means to care, Title V will specifically work with community health centers to increase their capacity to integrate mental health services with primary care to enhance access. To accomplish this agencies will provide training for primary care staff about behavioral health issues; provide training for behavioral health staff on the use of the electronic medical record; and encourage case management to coordinate primary care and behavioral health care. MCH will fund a variety of models of care and will facilitate the exchange of information from successful programs to others.

To improve access to standardized developmental screening for young children

Nationally, 17% of children have a developmental or behavioral disability such as autism, intellectual disability (also known as mental retardation),or Attention-Deficit/ Hyperactivity Disorder (ADHD); there are additional children with delays in language or other areas. Less than half are identified before starting school, impacting future development and readiness to learn. Improved standardized developmental screening identifies these delays early and enables children to receive early intervention services to be better prepared to learn when entering school.

Title V will coordinate with partners across systems to ensure that families have access to developmental screening for their children and will assist parents with the completion of ASQ & ASQ/SE through Home Visiting New Hampshire programs and Watch Me Grow initiative. MCH and SMS will also work with partners to: promote and support connections between professional organizations and service providers; participate in workgroups of the Autism Council and collaborate on submission for funding opportunities to create regional teams of experts on Autism.

To decrease unintentional injury, particularly those resulting from falls and motor vehicle crashes, among children and adolescents.

Injuries are among the most serious and under-recognized public health problem. In New Hampshire and in the U.S., unintentional injuries are the leading cause of death and hospitalization to children and adolescents, killing more in this age group than all diseases combined. Injuries are predictable and preventable through a public health approach. In the time period 1999 through 2006, there were 527 deaths in ages 1-24 due to unintentional injuries with a rate of 16.31 deaths per 100,000 people in that age category. The majority of unintentional injury deaths from age 6 to 24 are due to motor vehicle crashes. In NH, falls are also the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24.

Activities for motor vehicle injury prevention will include: development of a website hosted by the Department of Transportation geared towards parents of novice drivers; implementation of parent survey on graduated drivers licensing; facilitation of NH Teen Driving Committee on a monthly basis; revision of teen driving component of Strategic Highway Safety Plan.

To reduce exposure to lead hazards, asthma triggers and other environmental hazards to assure safe and healthy home environments

A growing body of evidence links housing conditions to health outcomes such as asthma, lead poisoning, lung cancer, and unintentional injuries. Children, especially those under age 6, are more likely to suffer persistent developmental delays, learning disabilities and behavioral problems as a result of their exposure to lead. Approximately 30% of New Hampshire housing stock was built prior to 1950 when lead paint was commonly used.

Morbidity associated with asthma is high. Emergency department use, hospitalization, decreased lung function and death can characterize the experience of both adults and children with uncontrolled asthma. Approximately 10% of NH adults and 8% of children currently have asthma and the prevalence is increasing. Approximately one-third of all New Hampshire children live in homes where a person smokes, making exposure to tobacco smoke a significant problem for these children. Health disparities for asthma occur by gender, age, educational level and household income.

By taking a "Healthy Homes " approach to these issues, MCH will address the environment and systems that affect the lives of families throughout the state. MCH will work with state and local partners to increase the number of Healthy Homes Specialists credentialed in throughout the state; create an operational checklist,
protocols, and referral network for healthy homes activities; and increase home visits for healthy homes assessment, education, outreach.

To improve oral health and access to dental care

Tooth decay is the most common chronic childhood disease, and is largely preventable through a combination of community, professional and individual strategies. Like the adult population, many children from low-income, uninsured families do not have access to regular oral health care and education. Many dentists do not accept Medicaid clients, nor do they have a sliding fee scale. Community water fluoridation is underutilized in New Hampshire. The NH Third Grade Healthy Smiles-Healthy Growth Survey found that approximately 44% of NH 3rd grade students experienced tooth decay and 12% of students had untreated decay at the time of the survey. Regional disparities in oral health were detected. Children attending schools with a higher free and reduced lunch program participation rate, as well as all students in Coos County, were more likely to have experienced decay, have untreated decay, and be in need of treatment, and they

were less likely to have dental sealants.

In addition to traditional direct and enabling services to increase access to oral health care, Title V will work in partnership with the DPHS Oral Health Program and the NH Department of Environmental Services (DES) to enhance the quality of the fluoridation of municipal fluoridation systems. The state fluoridation administrator will be responsible for managing the fluoridation system by promoting water fluoridation while the Title V staff will liaison with local systems to encourage appropriate levels of added fluoride in their systems. To build capacity and infrastructure, MCH will help facilitate fluoridation courses with DES to train water plant operators.

To increase family support and access to trained respite and childcare providers.

Over two-thirds of families of NH SSI CSHCN surveyed reported that they provide health care for their child at home; half of these families reported having to cut work hours to care for their child even while experiencing financial distress. The need for respite care for CSHCN is increasing, and availability of providers is limited. There are no coordinated respite services and extremely limited funding; what is available is not equally distributed throughout the State in the area of developmental disabilities. There is no respite funding available for behavioral health and an extremely limited number of respite providers with training.

Because this need was so strongly stated by families who most need this service, SMS plans to build public awareness and education about respite resources. SMS will create a competency-based curriculum with competency-based training and registry of respite providers and coordinate a Lifespan Respite Coalition.

To decrease the incidence of preterm birth

Preterm birth has enormous health, social and economic costs. Smoking during pregnancy accounts for 20-30% of low-birth weight babies and up to 14% of pre-term births. Of women using MCH-funded prenatal clinics (during the period 7/1/07-6/4/09), 43.2% smoked 3 months prior to becoming pregnant. Disparities are evident among racial, ethnic and socioeconomic groups. Since 1990, teens and young adults have had the highest rates of maternal smoking during pregnancy. Thirty-seven percent of NH women on Medicaid smoked during pregnancy. Interventions such as reducing maternal smoking have the potential to reduce the preterm birth rate and improve the health of infants and children and are within the scope of Title V responsibilities in expanding preconception care.

In order to address and understand the many causes and drivers of preterm birth, MCH will work with partners to develop the Maternal Mortality Review Panel; build the capacity of CHCs to better support smoking cessation to pregnant women and women of reproductive age; and develop a plan for preconception health that integrates models of chronic disease prevention and reproductive health.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	90	95	100	100	100

Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	16	14	23	23	27
Denominator	16	14	23	23	27
Data Source				screening records	screening records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments
DAILY TASKS:
Continued to manage the essential daily tasks of the program. (PB)

Monitored numbers of both refusals and misses in order to target educational efforts. (IB)

Performed educational outreach efforts through formal presentations and dissemination of printed brochures. (PB) (E)

SYSTEMS BUILDING:
Supported the work of the Newborn Screening Advisory Committee. One meeting was held. (IB)

Provided formal report to New Hampshire birth hospitals biannually, with statistics on their performance regarding newborn screening. (IB)

Utilized and evaluated the services of the Medical Consultant via the Service Delivery agreement. (IB)

Evaluated and assessed the process of reporting out of the newborn screening results to assure that the reports are reaching the physicians in need of them. (IB)

Collaborated with stakeholders to develop and revise protocols for management of infants identified as carriers via newborn screening. (IB)

Renewed contract with UMASS Newborn Screening laboratory for additional two years. (IB)

REGIONAL AND NATIONAL EFFORTS:
Participated in regional activities including NERGG, New England Metabolic Consortium Annual Meeting and New England Regional Collaborative (NERC) grant opportunity including the Long Term Follow-up Workgroup effort. (IB)

Attended APHL 2008 Newborn Screening and Genetic Testing Symposium In San Antonio Texas in November 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Continue to manage the essential daily tasks of the program.			X	
2. Continue to support the work of the Newborn Screening Advisory Committee.				X
3. Complete the Internal Operations manual to guide day-to-day program operations.				X
4. Plan and complete site visits to all New Hampshire birth hospitals.				X
5. Provide formal feedback via the QA Report to New Hampshire birth hospitals biannually with statistics on various aspects of the newborn screening process specific to their facility.				X
6. Perform the Data Linkage Process daily and monitor findings (refusals and misses) of this process.				X
7. Support educational efforts regarding newborn screening through periodic presentations and the dissemination of newborn screening brochures.				X
8. Utilize the services of the Metabolic Medical Consultant via the Service Delivery Agreement for handling clinically significant metabolic screening results.				X
9. Participate in regional efforts including NERGG, New England Metabolic Consortium, New England Regional Collaborative (NERC) grant effort and Long Term Follow-Up workgroup activities				X
10. Revise Newborn Screening brochure to include information for families on storage, retention and other uses of residual DBS.			X	

b. Current Activities

DAILY TASKS:
Continue to manage the essential daily tasks of the program. (IB)

SYSTEMS BUILDING:
Continue to support the work of the Newborn Screening Advisory Committee. (IB)

Provide QA Report to New Hampshire birth hospitals biannually with statistics on their performance regarding newborn screening. (IB)

Utilize the services of the Medical Consultant via the Service Delivery agreement and assess the benefits of this service for state medical providers. (IB)

Evaluate and assess the process of reporting out of the newborn screening results to assure that the reports are reaching the physicians in need of them. (IB)

Develop internal protocols for inclusion in the Internal Operations Manual currently under development. (IB)

Plan site visits to all NH birth hospitals. (IB)

Revise Administrative Rules for the program in regards to screening panel and filter paper fee. (IB)

Amend laboratory contract to add screening for Tyrosinemia to the state mandated panel. (IB)

Renew Service Delivery Agreement for Metabolic Medical Consultation Services. (IB)

New initiatives for the program are dependent upon resolution of the state budgetary crisis. (IB)

REGIONAL AND NATIONAL EFFORTS:
Participate in regional activities including NERGG, New England Metabolic Consortium Annual Meeting and New England Regional Collaborative (NERC) grant opportunity including the Long Term Follow-up Workgroup effort. (IB)

c. Plan for the Coming Year

DAILY TASKS:
Continue to manage the essential daily tasks of the program, including: daily reporting out of results back to birth hospitals; daily data linkage with vital records; provide technical assistance to birth hospitals and providers as needed; tracking and follow-up of infants who missed screening or need repeat screenings. (PB)

Monitor numbers of both refusals and misses in order to better target educational efforts. (IB)

Respond to requests for educational presentations and provide educational brochures to New Hampshire birth hospitals and providers as needed. (PB) (E)

Provide education about the new condition, Tyrosinemia, added to the panel, July 1, 2010, and education to hospitals regarding the fee increase for filter papers.

SYSTEMS BUILDING:
Continue to support the work of the Newborn Screening Advisory Committee, which is required to meet at least annually. (IB)

Provide QA Report to New Hampshire birth hospitals biannually with statistics on their performance regarding newborn screening. (IB)

Utilize the services of the Medical Consultant via a Service Delivery agreement and assess the benefits of this service for state medical providers. (IB)

Plan and complete site visits to all NH birth hospitals. (IB)

Develop internal protocols for inclusion in the Internal Operations Manual currently under development. (IB)

Continue development of long term follow-up plans for New Hampshire, collaborating with Special Medical Services, legal counsel and DPHS leadership. (E, IB)

Revise state newborn screening brochure to include information for families on storage, retention and other uses of residual DBS specimens. (E)

Provide an Annual Report on Newborn Screening to the Health and Human Services Oversight Committee in the Legislature.

Create new budgetary structure for Newborn Screening program for SFY12 and SFY13 that incorporates increased Filter Paper Fees to support NBS Coordinator salary and program support in addition to laboratory analysis. (IB)

Develop RFP for laboratory services, as current contract with UMASS lab will expire June 30, 2011.

REGIONAL AND NATIONAL EFFORTS:
Participate in regional activities including NERGG, New England Metabolic Consortium Annual Meeting and New England Regional Collaborative (NERC) grant opportunity including the Long

Term Follow-up Workgroup effort. (IB)

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**13389**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	13347	99.7	12	0	0	
Congenital Hypothyroidism (Classical)	13347	99.7	120	11	11	100.0
Galactosemia (Classical)	13347	99.7	5	0	0	
Sickle Cell Disease	13347	99.7	3	3	3	100.0
Biotinidase Deficiency	13347	99.7	2	1	1	100.0
Congenital Toxoplasmosis	13347	99.7	0	0	0	
Cystic Fibrosis	13347	99.7	45	10	10	100.0
Homocystinuria	13347	99.7	62	0	0	
Maple Syrup Urine Disease	13347	99.7	20	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	13347	99.7	0	0	0	
Argininosuccinic Acidemia	13347	99.7	1	0	0	
Citrullinemia	13347	99.7	1	1	1	100.0
Isovaleric Acidemia	13347	99.7	0	0	0	
Propionic Acidemia	13347	99.7	4	0	0	
Carnitine Uptake Defect	13347	99.7	2	0	0	
Methylmalonic acidemia (Cbl A,B)	13347	99.7	4	0	0	
Multiple Carboxylase Deficiency	13347	99.7	7	0	0	
Trifunctional Protein Deficiency	13347	99.7	0	0	0	

Glutaric Acidemia Type I	13347	99.7	1	0	0	
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	13347	99.7	79	1	1	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	13347	99.7	2	0	0	
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	13347	99.7	0	0	0	
3-Hydroxy 3-Methyl Glutaric Aciduria	13347	99.7	3	0	0	
Methylmalonic Acidemia (Mutase Deficiency)	13347	99.7	4	0	0	
Argininemia (Arg)	13347	99.7	0	0	0	
Carnitine Palmitoyltransferase II Deficiency (CPTII)	13347	99.7	0	0	0	
HHH	13347	99.7	0	0	0	
Multiple Acyle-CoA Dehydrogenase Deficiency (GA2)	13347	99.7	2	0	0	

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	54.9	55.9	55.9	61	60
Annual Indicator	54.9	54.9	60	60	60
Numerator					
Denominator					
Data Source				National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60	60	63	63	63

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
SMS continued contract arrangements to support NH Family Voices ($167,467) and Upper Valley Parent to Parent ($16,656). This represented the 17th year that Family Leaders were paid in consultant positions to SMS. Parents continued to participate in the MCH block grant preparation and the review process with federal partners. All SMS supported programs (contract and state supported) were required to conduct and submit parent satisfaction surveys focusing on quality of care indicators.

Child Health Services the primary contractor for Direct Services continued to administer their family satisfaction survey. Responses were very favorable among the forty-four percent that replied. Care Coordination services received a rating of 87% for "sensitivity to our values and customs". These numbers indicate that families have a cooperative and receptive platform for communication and collaboration about their children's services.

It was a focus of SMS activities to identify effective means for communicating with and recruiting families from diverse cultures to participate in the decision making process that impacts the system of care for CSHCN. Additional materials were translated into Spanish and all coordinators were offered training on the "Language Line" services available for translation. In addition, in SFY 2009 all agency contracts with SMS had a funded line item for cultural and linguistic supports in order to make services more accessible and responsive to families.

Through Title V support, Parent2Parent (P2P) responded to 91 Information & Referral inquiries and made 67 P2P matches. NH Family Voices responded to approximately 1200 calls from parents/families, disseminated 6,700 pieces of literature and trained 350 parents in healthcare financing.
NH Family Voices has also been supported to participate in a number (11) of Stateof NH and affiliated committees and advisories to insure that families are represented and that their needs are incorporated. Unfortunately, due to time conflicts Parent2Parent did not respond to the RFP issued to continue it's efforts in FY 10 and 11.

Through activities associated with NPM #6 and the Integrated Care for NH CSHCN grant, particular efforts were made to continue to recognize youth as experts in their own care by expanding the development of the Health Care Transition Coalition. The YEAH! Council (Youth Educating Adults about Healthcare) was fully operational and acted in concert with health care transition efforts.

SMS became the administering agency for a Family Support and community integration program called Partners in Health (PIH) in the middle of FY 09. This program is run in local communities (13 different sites) statewide with a focus on Family involvement and oversight. Each PIH site has a Family Council that leads the service visioning and community activity agenda. The Family Councils also determine the parameters and oversee distribution of flexible funding that is

available through the program. This small amount of funding ($15,000 per site) is made available to help meet the diverse needs of families so that they can focus on meeting the healthcare needs of their children with chronic health conditions. Access to these funds is not needs based and there is great flexibilty in the utilization of the funds due to the nature of the funding source, which is the Social Services Block Grant (SSBG). The SSBG is intended to help states "furnish social services best suited to meet the needs of the individuals residing within the State".

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued to contract with NH Family Voices		X	X	X
2. Continued contract with NH Parent to Parent		X	X	X
3. Collaborated with parent partners working on State Implementation Grants (administered through the Hood Center)			X	X
4. Required annual parent satisfaction surveys from all clinical programs	X			X
5. Recruited and involved parents and YSHCN on all planning and advisory groups				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Special Medical Services remains committed to supporting Family partnership and involvement. For the 18th year SMS has a contractual arrangement with NH Family Voices ($166,528). This budget is slightly lower than for the previous year but does not reflect a decrease in services, it is a more accurate reflection of actual spending from the past several years. The intent was to critically review actual spending and have planned budgets match this as closely as possible, to assist with State budget deficits. The goal was met to continue the process of improved communication and cooperation with statewide efforts. NH Family Voices (NHFV) has been regularly invited to the Title V Block Grant Needs Assessment planning meetings and Block Grant reporting meetings. SMS invited NHFV to participate in the rewriting of its rules and these will be in place as of July 1, 2010. SMS also has had a working relationship with the parent partners participating in two separate State Implementation Grants (administered by the Hood Center).

NH Family Voices has undertaken a statewide assessment of Family-to-Family connections. The report will be completed with FY 2010 activities.

In SFY 2010 all agency service contracts with SMS continued to have a funded line item for cultural and linguistic supports in order to make services more accessible and responsive to families. The new SMS application as well as outreach letters and resources have been translated into Spanish.

c. Plan for the Coming Year

Special Medical Services has institutionalized its commitment to supporting Family partnership and involvement. For the 19th year SMS will have a contractual arrangement with NH Family Voices (SFY 2011 budget is $168,068). MCH and SMS have conveyed the intent to maintain the current invitation for participation of NHFV in the Title V Block Grant reporting and planning meetings.

As a result of the fact that the Parent 2 Parent Vendor agency did not submit a proposal for services in 2010 and 2011 SMS, after extensive review of this change in services, decided to take the opportunity to incorporate into the 2010 NHFV contract an extensive statewide assessment of Parent-to-Parent activities and resources. At the start of SFY 2011 it is expected that NHFV will have completed the assessment and compiled a report that includes recommendations for continued services in the State of NH. SMS will review these recommendations and begin to put in place the supports and structure needed to implement them.

SMS also applied for and was chosen to have the services of a MCHB funded Graduate Student Intern. In August of 2010 her final work product should be available. The goal of which is to: "Create a standardized and comprehensive framework for ongoing program evaluation for SMS for the next five years that is responsive to the needs of families of CSHCN and to federal and state required reporting."

The relationship between SMS and the parent partners participating in a State Implementation Grants (administered by the Hood Center at Dartmouth) will continue as part of their anticipated no cost continuation. SMS' role in this initiative is to form strong alliances, which are considered to be critical to sustainability planning as the SIG funding ends, and SMS is responsible to maintain and spread these efforts. In addition, SMS has applied for the next State ImplementationGrant for Epilepsy care and if funded the focus will be on Parent/Youth involvement and coordination of care efforts statewide.

SMS administration of the Partner in Health program will offer the opportunity to incorporate additional family input into statewide services for CSHCN. The PIH site Family Councils will be utilized. In addition there are plans to pull together a Council of representatives from each Family Council, one of the objectives will be for it to act as an Family Advisory to Special Medical Services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55.9	56.9	56.9	50	50
Annual Indicator	55.5	55.5	49.6	49.6	49.6
Numerator					
Denominator					
Data Source				National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	54	54	54

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments
For the third consecutive year, Medical Home development efforts for CSHCN have been supported with a contractual arrangement between SMS and the Center for Medical Home Improvement (CMHI) CMHI co-directors McAllister and Cooley are nationally recognized experts in Medical Home. This collaboration continued policy level initiatives, infrastructure development, and planning and technical support regarding the advancement of Medical Home activities in NH.

The CMHI facilitated "Beyond the Medical Home" federal grant ended on June 30, 2008. SMS' "in-kind" assistance of Coordinator staff (Hoerbinger) ended at that point. She remained available to offer support to the Medical Home practice based coordinators on an "as requested" basis. SMS is querying medical practices involved with previous CMHI / Medical Home grants to determine if they are still practicing the medical home philosophy, what SMS may be able to assist them with in order to do so and, how SMS can best serve them in their management of CSHCN. (See attachment)

In the course of updating the SMS website, information was included about "Medical Home in New Hampshire", links to AAP, CMHI and others. SMS more widely publicized its availability to help practices either create in-office Care Coordination positions and, or assist them technically to make Medical Home a reality in their provision of care.

A Family Education Workgroup was created that consisted of CMHI staff and parent partners. They developed a "Medical Home Teaching Guide" and a "Family Learner Workbook". These tools are designed for practices to facilitate teaching families about the medical home concept and are available through CMHI and NH Family Voices

The pilot project continued that had been initiated (in 2007) in concert with a major health insurance provider in NH. Anthem began piloting with CMHI the development and use of a code for care plan oversight. Practices working with CMHI and who asked for inclusion had to agree to meet certain criteria in order to be eligible for a $225 prospective payment for care plan development and monitoring for children with special health care needs. This investment was designed to contribute towards the future sustainability of practice-based care coordinators in the medical home. Harvard Pilgrim Health Care joined the pilot in April 2008. Four practices have been participants in the Pilot project.

In a separate but complementary effort SMS collaborated with the Hood Center at Dartmouth on their MCHB funded Integrated Services Grant for NH CSHCN. This collaborative initiative between SMS, the Hood Center, Family Voices, Anthem Blue Cross Blue Shield, and Child Health Services, continued to address the challenges faced by families and practices serving

CSHCN. This project focused on three areas: 1. Development of a three level consultative model of comprehensive care coordination that supports practice's development of care coordination within the context of a medical home; 2. Building capacity to meet the transition needs of YSHCN by providing tools and support to address the specific needs of youth who are transitioning to adulthood, including transitioning to adult primary care; 3. Developing collaborative infrastructure within NH to support and sustain a culturally competent integrated system of providing care coordination within medical homes.

SMS collaborated with the New Hampshire Pediatric Society to apply for and receive AAP funding for a statewide Open Forum on Autism that included a component on the Medical Home role for children with ASD. The first of two Open Forums was held in SFY 2009 and attended by 80 participants, including primary care providers, care coordinators, community based service providers, legislators, families and other stakeholders. The SMS Administrator also has been a member of the New England Genetics Collaborative (NEGC) workgroup on Medical Home, which has focused on issues of primary and specialty care co-management.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SMS Administrator actively participated in NICHQ facilitated Learning Collaboratives for Project Access				X
2. SMS coordinators facilitated Medical Home Practice meetings for medical teams and acted as a resource to practice-based coordinators (providing support and technical assistance).		X		X
3. Participated in Medical Home workgroup of the NEGC			X	X
4. Ongoing review and support for a state contracted program that offers financial sustainability to Medical Homes in NH.		X		X
5. Continued to contract with the Center for Medical Home Improvement				X
6. Facilitated and ran AAP funded Open Forum on Autism with Medical Home Management component.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

SMS has continued its contractual relationship with the Center for Medical Home Improvement. The focus is to influence macro system change; increase political and public understanding. The collaboration with the Hood Center on the ISG was expected to end as of May 30, 2009 but they did obtain a "no cost continuation". The plan for this continuation more integrally connected SMS community based care coordinators to practices through a process of education and technical support for patient centered team care planning. This process has provided technical assistance on care coordination and family centered care. The expectation is that many practices will translate this support into their own capacity to meet this need with ongoing consultation available from SMS consultation.

The involvement of SMS in the Project Access SIG continued and due to the support for a Title V leadership track the CSHCN Director (Collins) continued her participation in the Learning Collaboratives and program development. This grant has had a focus on co-management and medical home concepts as well as planning for long-term sustainability of technical assistance

and consultation to practices.

c. Plan for the Coming Year
Special Medical Services will continue its support for Medical Home Improvement through an issued contract titled, "The Medical Home Project for Children and Youth with Special Health Care Needs". The Center for Medical Home Improvement continues to be the vendor for this contract. Our ongoing goal for the future is to enhance existing health care systems in New Hampshire for CYSHCN, to provide explicit, proactive care including identification, care coordination, advocacy and patient / family education. Obstacles to improving primary care for CYSHCN include limited consumer involvement, inadequate provider reimbursement, poorly defined professional roles and a lack of systematic approaches to care. Based on these issues, expectations of the funded project will include, but not be limited to, the following:

-Initiation of communication regarding The Medical Home Model with community based agencies and within the health cares system.
-Development of awareness project of The Medical Home Model to include hospital and health network leadership, parent and families.
-Facilitation of dialogue with public/private payors regarding reimbursement for care coordination activities within Medical Home
-Provision of technical assistance to interested medical practices.

The relationship between SMS and the parent partners participating in a State Implementation Grants (administered by the Hood Center at Dartmouth) will continue as part of their anticipated no cost continuation. SMS' role in this initiative is to form strong alliances, which are considered to be critical to sustainability planning as the SIG funding ends, and SMS is responsible to maintain and spread these efforts. In addition, SMS has applied for the next State ImplementationGrant for Epilepsy care and if funded the focus will be on Parent/Youth involvement and coordination of care efforts statewide. This activity would build on the Medical Home investment at Dartmouth Hitchcock practices as well as working to unify all past partipants in Medical Home quality improvement initiatives across the state.

Overall activities for the coming year will focus on:
1. Medical Home outreach and awareness
2. Policy development
3. Statewide medical home improvement activities
4. Interfacing with State of NH Medicaid to incorporate medical home initiatives into planning.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61.9	62.9	62.9	68	67
Annual Indicator	61.9	61.9	67.3	67.3	67.3
Numerator					
Denominator					
Data Source				National Survey of	National Survey of

				CSHCN 2005-2006	CSHCN 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	67	67	70	70	70

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
SMS continued to participate in statewide and programmatic planning to improve the percentage of children with adequate insurance. These efforts have been related to those CSHCN who are 0-18 years old and also includes the needs of young adults 18-21 year old.

In SYF 09 through Title V support, NH Family Voices hosted and presented workshops across the state on financing healthcare for parents/families of CYSHCN. At 6 different Workshops, 350 parents were trained at these "Paying the Bills" sessions.

The HC-CSD Coordinator (Allen) continues to work with Medicaid (Disability Determination and Prior Authorization departments) and Family Voices to provide intake services, care coordination and service utilization for children newly accepted for Medicaid by the HC-CSD eligibility pathway ("Katie-Becket like"). SMS continued to receive the list from SSI of children from NH who were newly approved for SSI. Outreach to children and youth newly enrolled in SSI was expanded. SMS began piloting outreach to any child or youth, newly enrolled in SSI, with a medical diagnosis even if they had Medicaid. This resulted from previous surveys of families that indicated that the assumption that children/youth with Medicaid were having their questions/needs met was erroneous. In addition, SMS began to send written outreach letters with information about local resources to those families of children with developmental and mental health/emotional/behavioral diagnoses. This effort has also been replicated in our population of children newly enrolled in Medicaid through HC-CSD.

In SFY 2009, of the 396 children/youth newly enrolled in SSI (who were not already affiliated with SMS) eighty families received outreach and follow-up for their child with a medical condition and three hundred and sixteen families received outreach resource letters for their children with developmental, learning, PDD or mental illness diagnoses. In SFY 2009, there were 314 children newly enrolled in Medicaid through HC-CSD (Home Care for Children with Severe Disabilities).

One hundren and ten of them received outreach for support and 204 received outreach resource letters for the statewide systems available to meet the needs of children with ASD, Developmental Disabilities and Mental Health diagnoses.

Information from Cover the Uninsured regarding health care coverage was distributed in English and Spanish at the:
Annual Association Infant Mental Health Conference in North Conway, NH on September 22 and 23, 2008
Resource Fair at the Adoptive Care Conference in North Conway on September 29, 2008
Early Learning NH Conference October 25, 2008

SMS sponsored/contracted services (i.e.: clinics, nutrition, feeding & swallowing) continued to explore and expand third party reimbursement. This has helped to build the infrastructure necessary to allow for increased capacity to serve those children without insurance. Care coordinators continued to familiarize themselves with options for insurance and other financial resources (local, state, regional and national) for families to access.

Timely and accurate date on insurance status is integral to developing effective initiatives and the SMS Data Specialist (Bernard) is the primary contact for the SMS Data Integrity Enhancement Initiative for data clean up and system enhancements to streamline the SMS database, to insure more efficient analysis and reporting in the future.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Follow-up of SSI referral transmittals has been reviewed and changes have begun in outreach and information and referral.	X	X		
2. Outreach and short-term coordination for families of children enrolled in Medicaid based on their chronic health condition	X	X		
3. Exploration of strategies for insurance re-imbursement for nutrition services continue			X	X
4. Revision of SMS policy/procedure and data collection methods continue		X		X
5. Parents/families offered training on healthcare financing by NH Family Voices - "Paying the Bills"		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
SMS' alignment with the Bureau of Developmental Services has allowed for collaboration with other programs that offer support to families (Area Agencies, Early Intervention and Partners in Health). This effort continues to improve the process of family centered services. SMS continues to participate in planning discussions about ideal sources of support as well as when it is appropriate to collaborate and "braid" funding to meet the needs of CSHCN. Care planning by SMS coordinators illustrates planning for supporting families and youth in efforts to attain and maintain consistent insurance and financial resources for health related costs. In addition, SMS continues to maintain its Equipment Bank, which allows children to access DME that has been

used but refurbished by a Certified Equipment Vendor. Despite the fact that the State of NH has been limiting costs and cutting budgets SMS has been able to continue to support the costs of some health related needs for children and youth who meet financial eligibility criteria (>185% of FPL).

Outreach to children and youth newly enrolled in SSI and Medicaid through HC-CSD has been ongoing. This year SMS began to survey outreach resource letter recipients to determine their level of satisfaction with this effort. Results will be collated and reviewed next fiscal year.

c. Plan for the Coming Year

The State of NH is expecting, as are so many other states, continued financial shortcomings and there will be continued emphasis on limiting costs and cutting budgets. SMS has reviewed its priorities and resources and been able to protect funding to continue to support the costs of some health related needs for children and youth, who meet financial eligibility criteria (>185% of FPL). In the coming SFY, SMS has budgeted monies to support these needs (ex: DME, medications, specialty services/providers and transportation). The need for these funds as it relates to Insurance coverage and Insurance adequacy is expected to be dramatically increased. NH Medicaid has made some changes in their prescription coverage for which SMS has already begun to receive requests for assistance. An example of these changes are "transparency" improvements in the system that disallow the coverage of cost of OTC meds that are part of a compounded medication; this can include elements such as Co-enzyme Q10 critical for the care of many children with metabolic disorders. There are many compounding pharmacies in NH that are refusing to provide Medicaid services due to these payment changes. This has led to families needing assistance not only finding a new pharmacy but also in covering the shipping costs when the pharmacy is not local. The new issue for families in the next fiscal year is expected to be related to service caps and prior authorization hurdles that limit accessibility for CYSHCN. SMS does have a cooperative relationship with Medicaid and will continue to advocate for the needs of CSHCN.

SMS has also begun and expects to continue to receive requests for assistance with insurance premiums, co-pays and deductibles. Generally SMS has not assisted with premiums but with the economic changes it is a dilemma when the realistic outcome of this denial is no insurance coverage at all. The population that SMS has seen the greatest need from are children who are legal residents but have been so for less than 5 years (and therefore are not eligible for Medicaid) and for youth ages 18-21 who age out of HC-CSD and/or their parents private health insurance (which they find to expensive to continue).

SMS will continue to work with identified partners in New Hampshire who are interested in improving the access to and adequacy of insurance for children, including CSHCN. These groups include the NH Children's Advocacy Network, the Council for Children and Adolescents with Chronic Health Conditions and NH's new Autism Council. The Autism Council is charged with the need to improve public and private insurance coverage for recommended services for those children and youth diagnosed with Autism Spectrum Disorder, SMS' Administrator (Collins) is a workgroup chair.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2005	2006	2007	2008	2009

Data					
Annual Performance Objective	78.4	79.4	79.4	86	86
Annual Indicator	78.4	78.4	85.8	85.8	85.8
Numerator					
Denominator					
Data Source				National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86	86	89	89	89

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
The SMS Community Based Care Coordination program staff identified three goals and accomplished the following activities.

Goal 1- Improve communication with physicians and other agencies through increased outreach using a recently developed Information Packet and a power point presentation about SMS, referred to as "The Roadshow". Care Coordination staff increased their outreach visits to agencies they work with to provide formal presentations and one Coordinator Beth Allen provided a number of extra presentations. Seven presentations of the SMS Roadshow were completed. There were limited visits to medical practices to do the "Roadshow". In addition an SMS Information packet containing fact sheets about all of our programs was developed.

Goal 2 -- Clarify how the various agencies serving CSHCN can provide non-duplicative services and how the SMS care coordination model is best utilized. This process, started in fall of 2007 with the conference "Working Together Toward a Common Goal", and was enhanced by the administrative alignment with Partners in Health in January 2009. This is a statewide family

support and community education program that serves children with chronic medical conditions. Previously, this program was contracted out to the Hood Center at Dartmouth and they subcontracted community family support services for families of children with chronic illnesses. This is a valuable program and no changes were made in the direct support to families. However, by eliminating the Administrative contract, funds were saved and reallocated for other direct service needs. This alignment is logical and offered a great opportunity to strategically develop policies and procedures for identifying which agency will have lead involvement and protocols for families involved in both SMS and PIH. Planning for joint meetings was begun in the spring of 2009 after the new Program Manager had been hired. This will be an ongoing process.

Goal 3- Continually improve the quality of our services to families. Quality assurance work included the review of all the FY 2008 Annual Reports and a planning process to target areas to improve quality and family satisfaction. This resulted in the formation of workgroups to look at child-family assessment and levels of care based on complexity and to articulate how the SMS Care Coordination presents itself to the public. In addtion we continued our work on care planning and added case presentations to the monthly meetings. We also promoted a focus on health care transition assessment and education for youth and families enrolled in care coordination and in the Neuromotor Clinic Program. The Neuromotor program provided transition medical summaries and assistance with referral to adult providers for all youth leaving the program at age 21. Internal development included revision of forms and an improved referral process among SMS programs especially the Nutrition, Feeding and Swallowing Programs with the Care Coordinators and clinic programs.

SMS continues to outreach to newly identified CSHCN, particularly to CSHCN identified by SSI enrollment as well as those identified by HC-CSD Medicaid enrollment.

All SMS staff participated in a variety of state committees and advisories to ensure that the needs of CSHCN are represented as well as to help to identify collaboratives that can work together instead of creating parallel initiatives. Representation of SMS care coordination and administrative staff on relevant committees included; the state Council for Children and Adolescents with Chronic Health Conditions, the Asthma Control Planning Group, the Interdisciplinary Coordinating Committee for Part C, the Mental Health Planning Advisory Council, the NH Children's Advocacy Network, NH Birth Conditions Advisory, NH Newborn Screening Advisory, Child Well-Being Task Force, Child Health Month Coalition and the Community of Practice on Transition. SMS is also represented on two of the NH Autism Council workgroups.

SMS continued it's collaboration with the Hood Center at Dartmouth on the MCHB funded Integrated Services Grant for CSHCN to assist primary care practices to develop capacity to meet care coordination needs of CSHCN. Our SMS coordinators were in positions to continue to offer care coordination consultation as the no cost continuation ends.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continuous improvement activities for care coordination				X
2. Assumed administrative responsibility for the Partners in Health Program		X		X
3. Intra agency referrals improved				X
4. SSI care coordination outreach is expanded		X		X
5. Expanded outreach and information sessions including SMS program presentation “road show”		X		
6. Development and use of SMS Program Fact Sheets			X	X
7.				

8.				
9.				
10.				

b. Current Activities
Community Based Care Coordination is offered statewide to CYSHCN. Children and families receive services through home visits and frequent phone follow up. SMS recently completed the development of new tools to refine the process for assessment of child complexity and family level of need for care coordination, using a new approach that incorporates formal family choice in the types of services needed and provided. This is one example of our care coordinators demonstrating family-centered care principles.

Nutrition, Feeding and Swallowing (NFS) services are more frequently linked to care coordination through a SMS Nurse Consultant who acts as a liaison between the programs.

We have had several joint SMS educational sessions (to review care coordination and family support services) and have begun to systematically explorec coordination roles with families. NH Family Voices provided education at one session about a shared value -- Family Centered Care. We are demonstrating the health care transition care planning process with our 12 to 21 year olds through monthly case presentations. In addition coordinators are bringing the new transition initiative to medical practices.

c. Plan for the Coming Year
Community Based Care Coordination will continue to be offered statewide to CYSHCN and SMS will continue to outreach to newly identified CSHCN. This will include increasing information and referral services to CSHCN identified by SSI enrollment as well as those identified by HC-CSD Medicaid enrollment. Especially in regard to assuring that those children with primary Mental Health or Autism Diagnoses receive timely information about services and agencies intended to assist them. Additional efforts at organizing and collaborating on a system of care are demonstrated by the involvement of SMS staff in the State of NH's new Autism Council -the SMS Administrator co-chairs the Early Screening & Diagnosis workgroup and the Program Manager is a member of the Employment and Independence (Transition) workgroup.

The Program Manager for Care Coordination who also functions as the state Transition Coordinator has been invited to be on a national advisory group for the newly awarded grant for the National Health Care Transition Center.

SMS will continue to work with practice coordinators and parent partners that have participated in the State Implementation Grant for children with Epilepsy -- Project Access. The Hood Center at Dartmouth has been the grantee and will be seeking a no cost extension to continue a focus on care planning and co-management. SMS has applied for the next round of Project Access grants and if funded the focus will be on the coordination of care statewide of this population of CSHCN.

SMS will continue collaborative work with NH Family Voices to assure that all staff are aware of and communicate consistently about the supports and resources that are available to families in the state. NH Family Voices has created valuable print materials and a great website that assist coordinators in this endeavor.

SMS will continue to collaborate with and have active dialogue with other agencies that are serving children and families in the state.

Completion of several protocols and processes that will improve Care Coordination will be priorities. These are the standard care plan, the Complexity Scale and Levels of Care Tool, the

intra agency referral form, and the diagnostic listing and analysis.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.9	5.9	52	52
Annual Indicator	5.8	5.8	51.6	51.6	51.6
Numerator					
Denominator					
Data Source				National Survey of CSHCN 2005-2006	National Survey of CSHCN 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	52	52	55	55	55

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
The Health Care Transition Coalition (HCTC) met five times. It is comprised of two pediatricians, parents and other health professionals, and serves as a sounding board for family and professional education issues for both SMS and NHFV. We promoted the creation of the Youth Advisory Council called YEAH --Youth Educating Adults about Healthcare in 2008 and NHFV provided program and fiscal oversight. YEAH members focused on the development of educational materials. The series "Ready? Get Set Go!" and the first edition of the YEAH newsletter were mailed out in winter 2009. SMS care coordinators are using these transition tools to assist youth and families in all SMS programs. YEAH also held a successful conference with Jonathan Mooney as the keynote speaker.

HCTC activities included outreach to providers through publication in the pediatric and family physician newsletters of our 2008 Survey of Adult Health Care Providers about Transition. This survey documented the need for improved coordination regarding transition and recommended strategies. We also compiled a referral listing of adult providers. We created a series of Transition Tips for the Granite State Pediatrician and posted materials on the YEAH website. We developed an on-line survey for Young Adults with Ongoing Health Conditions to capture the experiences of youth in SMS and in the Medicaid population regarding their experience with access to primary and specialty care, health insurance and health care knowledge and skills. The survey also asked how young adults with ongoing health conditions prefer to learn about health and this may direct our efforts in a new way. The survey will be sent out in FY 10. We provided talks to physician, family and other groups about health care transition. . Our most exciting transition accomplishment was the joint effort of the HCTC and the YEAH Council in the creation of a very catchy poster about health care transition that inspired us to develop additional materials in FY10.

In SMS, the Program Manager also functions as the Transition Coordinator and as such participated in several ongoing transition initiatives, including the IDEA sponsored Community of Practice on Transition, the NE Genetics Collaborative monthly conference call on transition, attendance at the NEGC annual meeting and being a member of the Autism workgroup on Employment and Independent Living.

The Health Care Transition Coalition met every two months to accomplish our two Work plan outcomes --that families and youth will be knowledgeable regarding health care transition and that youth will be able to successfully complete the transition process and transfer to the adult health care system and that health care providers will have improved health care transition supports and education for the services they provide to youth and families and will have increased collaboration with other professionals and health care providers about transition.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote and coordinate health care transition activities				X
2. Consult to medical practices as requested		X		X
3. Meet quarterly with the Health Care Transition Coalition to advise on HCT activities and plan to promote improved transition practices statewide.				X
4. Survey Adult primary care providers about needs with YSHCN.			X	X
5. Participate in collaborative educational programs with community partners to describe health care transition.		X		X
6. Improve transition services to youth enrolled in Special		X		X

Medical Services through ongoing staff training.				
7. Collaborate with the Youth Advisory Council on projects.			X	X
8. Increase physician knowledge about transition through publication of “Transition Tips” in the Granite State Pediatrician.				X
9. Assess knowledge and needs of YSHCN about transition through development of a youth survey.			X	X
10.				

b. Current Activities
The Health Care Transition Coalition met every two months.

The HCTC is meeting both Work Plan outcomes with the "Ticket to Adult Health Care Independence" campaign. Materials were developed, including a catchy poster, (jointly designed by YEAH and the HCTC) and specific educational materials for providers to give to parents and youth to start the health care transition dialogue. The campaign was launched this spring and has enlisted SMS and PIH coordinators, HCTC and YEAH group members to present these educational packets to 130 pediatric and family physician practices.

SMS posted a web-based survey for young adults to learn more about their experience with access to primary and specialty care, health insurance and health care knowledge and skills. This was marketed through postcards mailed to SMS' current and former enrollees and to a target population of disability eligible Medicaid recipients. Access to it was through the YEAH website and on Facebook. Analysis of the small number of responses will take place in July. SMS Care Coordinators presented transition focused cases at their monthly meetings.

c. Plan for the Coming Year
Monitor and support the individuals providing site visits to share the "Ticket to Adult Health Care Independence" Campaign through the fall 2010. HCTC will continue to meet and will have oversight of the progress of the campaign and will develop plans for continued educational efforts to support practices. Feedback from the first round of practices involved will be collected and reviewed to incorporate any necessary changes into the process to facilitate optimum success.

SMS will evaluate the success of this campaign by using the Practice Materials Evaluation pre and post visits.

A Health Care Transition webpage will be posted on the SMS website. A more dynamic webpage will be available through NHFV and this site will include tools and links for professionals and families.

SMS will find venues to provide transition education and participate in any conferences where this is an opportunity. One such opportunity is the joint presentation by SMS and NHFV on "What's Health Got to Do with Transition" for a primarily educator focused conference in the fall.

The results of the Youth survey will be analyzed and summarized for both the HCTC and YEAH! Council.

SMS Care coordinators will continue to offer transition assessment and education and include the primary care providers in the process so that the transfer of care to adult providers is a coordinated effort.

Special Medical Services transition activities are part of the work of the Program Manager. This limits some of the activities that SMS is able to participate in however in the coming year activities will include: Continued co-direction of the HCTC, management of the Ticket to Adult Health Care independence, participation in the NEGC transition workgroup, collaboration with the Community

of Practice on Transition (including a presentation on Health care transition at the annual meeting), and participation on the National Health Care Transition Center Advisory group (newly awarded to the Center for Medical Home Improvement).

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	87	87	82	85
Annual Indicator	86.3	82.5	76.3	84.6	81.0
Numerator	12990	12418	10860	12041	11528
Denominator	15052	15052	14233	14233	14233
Data Source				CDC Survey	CDC Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	85	86	87	88	89

Notes - 2009
The numerator was obtained by using the most recent CDC National Immunication Survey rate for NH (Qtr 1/2009-Qtr 4/2009) - available from the NH Immunization Program for 4:3:1:3:3:1 - and applying it to the denominator. The denominator is two year olds in NH in 2007, from the US Bureau of the Census Estimates Branch.

Notes - 2008
The numerator was obtained by using the most recent CDC National Immunication Survey rate for NH (Qtr 3/2007-Qtr 2/2008), available from the NH Immunization Program, and applying it to the denominator. The denominator is two year olds in NH in 2007, from the US Bureau of the Census Estimates Branch.

Notes - 2007
The numerator was obtained by using the most recent CDC National Immunication Survey rate for NH (revised February, 2008 estimates), available from the NH Immunization Program, and applying it to the denominator. The denominator is two year olds in NH in 2007, from the US Bureau of the Census Estimates Branch.

2007 data was corrected in the spring of 2009.

a. Last Year's Accomplishments
The latest National Immunization Survey showed that over 80% of New Hampshire children 19 - 35 months of age had received the recommended number of vaccine doses in 2008, placing New Hampshire among the top 5 states in the country.

MCH ACTIVITIES:
MCH continued to collaborate with the NH Immunization Program using the MCH contract

agencies' Co-CASA results as part of its quality improvement activities for site visits and agency workplans. New Hampshire has continued to do well in immunizing its children, primarily on account of it being one of six states with Universal Immunization status, which provides vaccine at no cost, to all children birth through the age of 18 years.

The FY09 outcome for the performance measure of the MCH-funded community health centers pertaining to the 4:3:1:3:3:1 vaccination by 24 months of age ranged from 63% to 98%, with an average of 94%. (IB)

MCH continued to work with Immunization Program staff to disseminate information to the MCH contract agencies, MCH Home Visiting contract agencies, and to Healthy Child Care New Hampshire child care health consultants on any changes or updates regarding vaccines to children and adolescents through mailings and meetings. At the Fall 2008 meeting of MCH-funded agencies' program coordinators, NH Immunization Program staff gave a presentation of Immunization Through the Life Cycles, a new approach to encouraging immunizations to people of all ages.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with the NH Immunization Program on any state or local activities.			X	X
2. Communicate immunization policy changes and immunization updates to Title V-funded agencies				X
3. Collaborate with the NH Immunization Program in using Co-CASA results from Title V-funded community health agencies for quality assurance activities including site visits and performance measures.				X
4. Continue to include immunizations in the information updates to the MCH Home Visiting contract agencies, and to Healthy Child Care New Hampshire child care health consultants.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH ACTIVITIES:

MCH staff continues to work with staff from the 13 community health centers and one pediatric primary care center to improve their immunization rates through site visits and achieving the identified performance measure through workplan activities. (IB)

MCH continues to work with Immunization Program staff to disseminate information to the MCH contract agencies, MCH Home Visiting contract agencies, and to Healthy Child Care New Hampshire (HCCNH) child care health consultants on any changes or updates regarding vaccines to children and adolescents through mailings. (IB)

On March 23, 2010, the Immunization Program hosted the NH Immunization Annual Conference: Vaccinate for Life: Strategies for Success. Dr Ari Brown, MD FAAP spoke about new strategies in discussing immunizations with parents in light of growing concerns about autism and other heath problems and how they may or may not be related to immunizations. (PB, IB)

c. Plan for the Coming Year
MCH staff will continue to work with staff from the 13 community health centers and one pediatric primary care center to improve their immunization rates through site visits and achieving the identified performance measure through workplan activities. The agencies' immunization performance measure for FY11 has been changed to "Percent of children 24-35 months who had 4 DtaP/DT, 3 polio, 1 MMR, 3 H influenza type B, 3 hepatitis B, 1 varicella vaccine or documented history of disease or lab confirmation of disease, and 4 doses of pneumococcal vaccine (4:3:1:3:3:1:4) by age 24 months" at the recommendation of the NH Immunization Program. (IB)

At the Fall 2010 MCH Coordinators' Meeting, agencies will be sharing successful strategies for achieving success in its performance measures. We will be asking a community health center (Indian Stream, in the northern part of the state) that uses the TIDE Program (Teaching Immunization Delivery and Evaluation Program) for educating its clinical and non-clinical staff regarding immunizations to present their program to the other 13 community health center clinical coordinators. (IB)

MCH will continue to work with Immunization Program staff to disseminate information to the MCH contract agencies, MCH Home Visiting contract agencies, and to Healthy Child Care New Hampshire (HCCNH) child care health consultants on any changes or updates regarding vaccines to children and adolescents through mailings. (IB)

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	6.9	6.9	7.3	7.2
Annual Indicator	6.9	7.2	7.4	7.7	7.7
Numerator	195	205	203	212	212
Denominator	28128	28653	27473	27473	27473
Data Source				Birth data	Birth data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.5	7.4	7.3	7.2	7.1

Notes - 2009
Data is unavailable. 2008 data is used as an estimate.

Notes - 2007
Birth data is resident occurrent births only, i.e. out-of-state data is not available.

a. Last Year's Accomplishments

The Adolescent Health Program continued to meet with partners to address the strategic plan. (IB)

FPP continues to target adolescents and young people for pregnancy prevention through the contracted community educators, and to promote evidence-based curricula. (PB, IB)

The Adolescent Health Program partnered with the Department of Education (DOE) as the newly elected Co-chair of the Coordinated School Health Council, including training on the School Health Index, and as the MCH representative on the DOE related council. (IB, PB)

The abstinence education contract ended as of June 30th, 2009 because of the discontinuation of federal funding. The state advisory committee continued to meet. (PB, IB)

The MCH social networking site web outreach continued. (ES)

The Adolescent Health Program continued to conduct site visits and performance measures for primary care and adolescent clinics, with the MCH QA program. (IB, PB)

The FPP continues to offer confidential reproductive health services to adolescents statewide as required by Title X. Education and reproductive health services continue at teen clinics. (DHC)

The FPP in collaboration with the Prenatal and Home Visiting programs engaged the services of a student intern to assist in the research towards the development of a model for preconception and interconception services. Data collection indicates and supports NH's status of having the lowest teen birth rate in the nation. Data also supports that the area of greatest concern for teen births is 18-19 year olds, as they account for three-quarters of the teen births in NH. The model will be useful in seeking out funding for targeted programming for 18-24 year olds. (DHC)

The Adolescent Health Program Coordinator resigned effective Fall 2009. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to offer confidential reproductive health services through Title X clinics and teen clinics.	X			X
2. Chair and move forward the State Adolescent/Young Adult Sexual Health Task Force planning initiative, in which teen pregnancy prevention will be a part of issues addressed				X
3. Continue to develop model for preconception/interconception care services to target older teens (18-19 year olds) and young adults (20-24).				X
4. Continue to contract evidence-based community education curricula with reduced funding			X	X
5. Represent MCH on related statewide councils.				X
6. Continue to contract abstinence education, pending federal funding.			X	X
7. Continue to convene the state abstinence education advisory committee.				X
8. Continue Adolescent Health Strategic Plan implementation.				X
9. Continue to contract adolescent and primary care health services.	X			X
10.				

b. Current Activities

The Teen Pregnancy Prevention Initiative through its planning process determined to broaden the scope to be more inclusive of sexual health needs and is currently known as the "Adolescent/Young Adult Sexual Health Taskforce". The group feels this will allow for more partnership, as well as a more holistic approach to how teen pregnancy can continue to be addressed. The need-targeted evidence-based Teen Pregnancy Prevention Plan will now be expanded to include the broader scope of sexual health. Levels of efforts are contingent upon future funding. (IB)

The FPP will continue to promote and support community education activities and the use of evidence-based programs. FPP will continue to target adolescents and young people through the Family Planning contracts. Contracted community educators will continue to collaborate with schools and youth serving agencies and
provide targeted teen pregnancy prevention. The level of programming will be contingent upon continued funding. (PB, IB)

The FPP continued to promote the implementation of evidence-based curricula in schools and youth serving agencies. However due to budget constraints these efforts have been minimized and will no longer be funded at the levels it has been in the past. (PB)

The Adolescent Health Program continues to partner with the Department of Education (DOE) on the Coordinated School Health Council (CSHC) and as the MCH representative on the DOE related council. (IB, PB)

c. Plan for the Coming Year

The FPP continues to offer confidential reproductive health services to adolescents statewide as required by Title X. Education and reproductive health services have also continued through teen clinics. Statewide access of the program is contingent upon continued funding. (DHC)

A new federal proposal will be written for the administration of abstinence education funds. It is hoped that this will continue through the same contract with Catholic Medical Center. The abstinence education state advisory committee will continue to meet and provide guidance and oversight to the abstinence education program. (PB, IB)

Program Managers are participating in the Office of Minority Health's survey of prenatal providers in the Manchester and Concord areas of the state. Surveys encompass the needs of the refugee and immigrant population and will be focusing on access into care. (IB)

MCH staff also will continue to be involved in the Perinatal Depression Collaborative. This is a group of professionals interested in the screening and treatment of depression in women in the perinatal period. (IB)

MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

The FPP in collaboration with the Prenatal and Home Visiting programs will continue to work on the preconception/interconception care program model targeted at teens and young adults. Contingent upon approval and funding, efforts to pilot and implement the plan will move forward (DHC)

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	42.4	42.4	42.4	42.4	44
Annual Indicator	42.4	42.4	42.4	42.4	54.5
Numerator	249	249	249	249	1644
Denominator	587	587	587	587	3015
Data Source				2006 3rd grade survey	2009 3rd grade survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	54.5	54.5	54.5	54.5	60

Notes - 2009
Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The data for 2009 is new.

Please note: statewide prevalence estimates are weighted to represent NH third grade students, and to account for selection probability and non-response. Using the weighting, the result for this measure is 60.4%, not 54.5.

Notes - 2008
Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The next data from the survey will not be available until the fall of 2009.

Notes - 2007
Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The next data from the survey will not be available until the spring of 2010.

a. Last Year's Accomplishments
DATA ANALYSES:
The OHP maximized the use of limited resources by collaborating with the DPHS Chronic Disease Epidemiologist and Obesity Prevention Program (formerly the Nutrition and Health Promotion Program) to collect and analyze data (including sealant prevalence) from 3,051 third grade students in 81 schools in New Hampshire's Healthy Smiles-Healthy Growth Oral Health/ BMI Third Grade Survey. (IBS, PBS, ES, DS)

SYSTEMS BUILDING:
The OHP collaborated with the Medicaid Dental Director to improve access to oral health care by increasing the number of enrolled dental providers that will increase utilization of protective dental sealants on children's teeth. (IB, ES, PBS, DS)

The OHP collaborated with the Medicaid Dental Director, the New Hampshire Dental Society, the Concord Sealant Coalition and other communities to promote the effectiveness of sealants as an evidence based approach to oral disease prevention through school sealant programs that also link identified children with restorative care and a "dental home." (IB, PBS, ES, DS).

The OHP collaborated with the DPHS Diabetes Program to inform and educate diabetes stakeholders about the scientific evidence that supports the impact of oral health on diabetes disease management. (IB, PBS, ES, DS.)

The OHP collaborated with key stakeholders to support the June 9, 2010 opening of a new dental center to provide access to oral health care for all residents of Sullivan County that has the lowest dentist to patient ratio in New Hampshire. (IBS, PBS, ES, DS)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collect, analyze and report on data from the Healthy Smiles-Healthy Growth Third Grade Survey that provided the first regional data on the body mass index and oral health status, including the presence of dental sealants, among New Hampshire's childr		X	X	X
2. Partner with the Head Start State Collaborative Office and the NH Pediatric Dental Society to launch and implement the American Academy of Pediatric Dentists' (AAPD) Head Start Dental Home Initiative.		X	X	X
3. · Collaborate with the Women, Infants and Children (WIC) Program to improve access to preventive and restorative oral health care for enrolled children at higher risk for ECC, untreated decay, and history of decay, especially for WIC families that li				X
4. · Collaborate with the DPHS Diabetes Program to educate medical and dental professionals about the impact of oral health on diabetes disease management and link diabetes patients to oral health care.				X
5. · Collaborate with the Medicaid Dental Director, the NH Dental Society, the Concord Sealant Coalition and 11 state funded school sealant programs to promote the effectiveness and sustainability of school sealant programs that also link identified chi				X
6. Collaborate with the Chronic Disease Epidemiologist to annually collect and analyze oral health data and provide programmatic feedback on the presence of dental sealants among NH's third grade students.				X
7. · Complete and distribute the strategic oral health workforce plan that will affect the supply, diversity, cultural competence, composition and distribution of NH's oral health workforce.				X
8.				
9.				
10.				

b. Current Activities

DATA ANALYSIS:
The OHP is collaborating with the Chronic Disease Epidemiologist on the publication of the state's oral disease burden report, NH Oral Health Data, 2010 regarding the oral health status of NH residents.

SYSTEMS BUILDING:
The OHP's is working with the Medicaid Dental Director to inform and educate the dental professional community to increasing the number of enrolled dental providers and improving access to preventive and restorative oral health care for NH's underserved populations. (IB, ES, PBS.)

The OHP is collaborating with the Medicaid Dental Director and the NH Dental Society to promote the evidence-based effectiveness of school sealant programs that also link identified children with restorative care and a dental home.(IB, PBS, ES, DS)

The OHP is working with the New Hampshire Office of Head Start Collaboration, and other stakeholders on the American Acadamy of Pediatric Dentistry (AAPD) Dental Home Initiative to improve access to preventive and restorative care for Head Start children at higher risk for ECC, untreated decay, history of decay, and urgent treatment. (IB, ES, PBS, DS).

The OHP is collaborating with VT/NH Bi-State Primary Care Association to develop a strategic oral health workforce plan that will affect the supply, diversity, cultural competence, composition and distribution of NH's oral health workforce, especially oral health professionals who treat very young children and residents of rural,
underserved NH communities. (IBS, PB)

c. Plan for the Coming Year
DATA ANALYSIS:
Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The data for 2009 is new.

Please note: statewide prevalence estimates are weighted to represent New Hampshire third grade students, and to account for selection probability and non-response. Using the weighting, therefore the adjusted target for this measure is 60.4%, not 54.5%.

The OHP will continue working with the Chronic Disease Epidemiologist to annually collect and analyze oral health data and provide programmatic feedback on the presence of dental sealants among NH's students enrolled in 21 school-based sealant programs in 181 (59%) of NH's elementary schools. (IBS, PBS, ES.)

SYSTEMS BUILDING:
The OHP will work with the Dental Director and Medicaid Program to inform and educate the dental professional community with the goal of increasing the number of enrolled dental providers and improving access to preventive and restorative oral health care. (IB, PBS, ES, PBS.)

The OHP will collaborate with the Dental Director and Medicaid Program, the NH Dental Society, the Concord Sealant Coalition and key stakeholders in Hillsborough to promote the sustainability and effectiveness of school sealant programs that also link identified children with restorative care and a "dental home." (IB, PBS, ES,
DS)

The OHP will collaborate with the New Hampshire Office of Head Start Collaboration and the New Hampshire Pediatric Dental Society to implement promising practices to improve access to preventive and restorative oral health care for Head Start children at higher risk for ECC, untreated decay, and history of decay, who live in the Tri-County region and Nashua. (IB, ES,

PBS, DS).

The OHP will collaborate with the Women, Infants and Children (WIC) Program to improve access to preventive and restorative oral health care for enrolled children at higher risk for ECC, untreated decay, and history of decay, who live in Enfield and Lebanon. (IB, ES, PBS, DS).

The OHP will release the Division of Public Health (DPHS) Strategic Oral Health Workforce Plan developed in collaboration with VT/NH Bi-State Primary Care Association and a Task Force representing a diverse group of oral health stakeholders. The DPHS oral health workforce plan will affect the supply, diversity, cultural competence, composition and distribution of New Hampshire's oral health workforce. (IBS, PB, ES)

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	36	60	60	80	0
Annual Indicator	0		1.2	1	1
Numerator			3		
Denominator			241716		
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	0	0	0	0	0

Notes - 2009
Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Calendar year 2009 is unavailable. At the annual federal review in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. The small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Notes - 2008
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Calendar year 2008 vital records death data is provisional, due to the fact that out-of-state data is incomplete.

At the annual federal review in Boston in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Therefore, we have removed the 2008 Standard Ratio result from the indicator and have "checked" the small numbers box. Note: the small numbers box is used when "there are fewer than 5 events AND when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Notes - 2007
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

US data source: http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

At the annual federal review in Boston in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events AND when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

a. Last Year's Accomplishments
The MCH Injury Prevention Program continued to lead efforts to decrease the number and rate of deaths to children aged 14 years and younger caused by motor vehicle crashes. In collaboration with many partners, positive outcomes have been accomplished through participation in strategic planning; outreach and education; and policy development. (IB, PB)

Certified car seat technician workforce:
Two car seat technician trainings (20 participants per class) and an update for current technicians were facilitated this year. (IB)

The Injury Prevention Program Manager recertified as a child passenger safety technician. This is a process that takes place every two years and requires taking an electronic test, completing a certain number of continuing education credits, participating in at least two community events, and getting five different car seat installations checked off by a senior instructor. (IB)

Safe Kids New Hampshire:
Through Safe Kids New Hampshire, a "tween" (eight to twelve year old) traffic safety project took place in several communities across the state. This consisted of teaching the children to not only buckle up correctly but also to spot any hazards surrounding a vehicle both while driving and parked. (PB)

The traffic safety cub-scout patch, designed by Safe Kids USA, also continued to be offered through Chevrolet car dealerships. It teaches Cub Scouts and their parents and caregivers about safety in and around vehicle through interactive learning stations set up at local dealerships. The entire process takes between 60 and 90 minutes. After the Scouts successfully complete all of the educational stations, they are presented with their patch. (PB)

Teen Driving Committee (TDC):
The Injury Prevention Program Manager continued to chair the monthly TDC. The TDC utilized the New Hampshire Strategic Highway Safety Plan as its action plan. (IB)

As part of the action plan, the development phase for a website for parents of novice drivers was entered into by the TDC and the Brain Injury Association of New Hampshire. This website will be housed on the Department of Safety's website. (IB)

A consultant was hired (with leveraged funds) to facilitate by phone parent surveys. The TDC designed the survey, which was undertaken with 18 parents of novice drivers who live across the state. When asked what they most would like to see on a web site, the majority of respondents answered the rules and regulations of driving in the state. This fits in nicely with the site being hosted by the Department of Safety. Some comments included, "Preparing for scenarios…like what to do if a deer jumps out in front of you. How many hours to spend in the car with them" and "Rules not only for New Hampshire, but for surrounding states; because often when we're practicing highway driving we are driving to another state. Also the situations kids will be put into, and how to discuss these with your kids." However, only half of the respondents had actually been to any website for information on teen driving. Most said they received information from things given to them by drivers' education instructors. Interestingly, those same parents said they would have liked to have known about a website for their number one source of information because it was easier. Additional information on methods used to get the word out about the website as well as suggested parental methods to make a better teen driver were also gathered. (IB)

The TDC funding proposal to the Department of Transportation was still in the process of being reviewed. The TDC will continue to monitor this and update as needed. (IB)

The TDC worked with legislators this past year on a bill strengthening the state's graduated drivers' licensing system (gdl) for novice drivers. The bill was voted down in the House. However, the TDC has continued to explore ways to work with law enforcement, driver education instructors, parents, and adolescents to increase awareness of the current graduated drivers' licensing system. (IB)

Last year, the TDC was approached by the University of North Carolina's Center for the Study of Young Drivers, Highway Safety Research Center. The CDC had funded them to help states understand the latest in gdl research and strategize initiatives designed to help tighten policy and laws. They were interested in working with the TDC on graduated drivers licensing in New Hampshire, which was reciprocated. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Train and certify child passenger safety technicians and instructors.				X
2. Continue to promote and distribute booster, convertible, and infant seats.			X	
3. Facilitate car seat checks.			X	
4. Develop parent website on novice driving.			X	X
5. Develop and facilitate strategic policy session for daylong symposium with University of North Carolina colleagues.				X
6. Revise teen driving section of Strategic Highway Safety Plan.				
7. Secure identified funding for ongoing planning and implementation of motor vehicle crash prevention activities.				
8.				
9.				
10.				

b. Current Activities

Car Seat Technicians:
There was a certified car seat technician update held in April 2010 with 2 presenters from car seat manufacturers, Britax and Combi, which over 70 technicians attended. (IB)

There will be two four-day trainings to certify car seat technicians this year. It is estimated that approximately 20 participants per class will be trained and pass the certification test. (IB)

New packets were released from Safe Kids USA called "Protecting Our Children and Youth" designed for car seat technicians to use in their communities as outreach education. (IB, PB)

Safe Kids New Hampshire:
Safe Kids New Hampshire is hosting a professional development session on New Hampshire and national data trends in car crashes involving children and adolescents. (IB)

Teen Driving Committee (TDC):
The TDC, in collaboration with colleagues from the University of North Carolina, held a symposium on graduated drivers licensing (GDL) in October of 2009. Approximately forty people attended. The symposium focused on data and research behind the use of gdl. Plans are being made to host a strategic policy symposium in June with the same partners. (IB)

Development of the parent website is continuing based on survey results. (PB)

The TDC is currently updating the teen driving section of New Hampshire's Strategic Highway Safety Plan spearheaded by the Department of Transportation. This serves as the TDC work plan for the upcoming year. (IB)

c. Plan for the Coming Year

Certified car seat technician workforce:
Two four-day certification trainings will take place as well as a one-day update for currently certified technicians. (IB)

The Injury Prevention Program Manager will need to recertify as a car seat technician in 2011. (IB)

The materials used for booster seat education will be updated including a version in Spanish. (PB)

Teen Driving Committee (TDC):
The TDC will finish the website specific to New Hampshire's graduated drivers' licensing system for parents. The website will be coordinated and supported in-kind with the help of the New Hampshire Department of Transportation and the New Hampshire Department of Safety. A marketing campaign to go along with the website will be developed, dependent upon funding. This campaign will include hard copy and electronic parent guides as well as media messages. (PB)

The TDC will facilitate with the help of the University of North Carolina's Center for the Study of Young Drivers, Highway Safety Research Center a large- scale parent phone survey. This will determine a baseline for attitudes and knowledge with respect to graduated drivers' licensing in New Hampshire. The survey will assess parental attitudes towards the different pieces of a model GDL system (permitting phase, restricted passengers and night driving, etc.). It will also determine parents' knowledge of the current GDL system in New Hampshire. The survey results will be collected and analyzed in a report. (IB, PB)

The TDC will also host a strategic policy development session with the University of North Carolina's Center for Young Drivers, Highway Safety Research Center. It is hoped that colleagues will forward any policy work discussed in the 2010-2011 legislative session. (IB)

The TDC will facilitate the implementation of the activities identified in the funded Department of Transportation proposal. Those include activities already discussed as well as a larger media campaign focused on parents.(PB)

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		45	45	50	49
Annual Indicator	45.9	43.8	48.7	46.8	55.1
Numerator					
Denominator					
Data Source				CDC report card	CDC report card
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	56	57	58	59	60

Notes - 2009
Data is from the CDC Breast Feeding Report Card, 2009: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.

Notes - 2008
Data is from the CDC Breast Feeding Report Card, 2008: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.

Notes - 2007
Data is from the CDC Breast Feeding Report Card, 2007: Outcome Indicators (www.cdc.gov). A numerator and denominator are not available.

a. Last Year's Accomplishments
According to the CDC Breastfeeding Report Card, 2009, New Hampshire surpassed the national rates in every one of the five outcome indicators, and surpassed or met the indicator for all of the process indicators, compared to national results or averages.

MCH has continued to work with WIC to share educational offerings, electronic informational updates. This included promotion of World Breastfeeding Week and organizing a viewing of the National Maternal Nutrition Intensive course put on by the Center of Public Health Education and Outreach at the University of

Minnesota which had several seminars focused on breast-feeding. (IB, PB)

MCH's Prenatal Program Coordinator represented MCH on the NH Breastfeeding Task Force and attended the annual conference in June 2009. (PB)

MCH continued to keep health professionals informed of available breastfeeding services and information in the state. (IB, PB)

The MCH Child Health Nurse Consultant/SIDS Program Coordinator continued to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. (PB)

MCH explored the decision with MCH contract agency staff, and with WIC state level staff, to add a breastfeeding or WIC enrollment performance measure to the workplans of the prenatal or child health MCH contract agency workplans for FY10. New measures on breastfeeding and WIC enrollment were added to the Child Health workplan for FY10. (IB)

MCH staff communicated with the community health center staff through email and at the Fall MCH Coordinators' meeting about encouraging use of the WIC Medical Referral Form, which can now be utilized electronically to facilitate referrals to WIC. (IB)

MCH staff met with WIC staff on how to better collaborate on the state and local levels to improve WIC enrollment by MCH contract agency clients, and increase breastfeeding rates among MCH contract agency clients. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with WIC and the NH Breastfeeding Task Force on activities to enhance breastfeeding statewide, including awareness of World Breastfeeding Week.			X	X
2. Collaborate with WIC, the NH Breastfeeding Task Force, and the DPHS Breastfeeding Integration Committee on activities to enhance breastfeeding in MCH Title V-funded agencies.			X	X
3. Promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices.			X	
4. Work with MCH contract agencies through quality assurance activities (workplans, site visits) and meetings to encourage activities to promote breastfeeding and WIC enrollment among clients of MCH contract agencies.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH-funded community health programs are carrying out workplan activities supporting two new Performance Measures, one regarding infants exclusively breastfed by 4 months, and one regarding WIC enrollment. (IB)

MCH continues to work with WIC to share educational offerings, electronic informational updates to the agencies and programs supported by MCH. (IB)

MCH continues to promote breastfeeding in its SIDS risk reduction activities. (PB)

MCH and WIC jointly promoted Text4Baby, a mobile phone-based health promotion program that includes positive breastfeeding messages. (PB)

MCH and WIC surveyed their contract agencies in 2009 to assess local collaboration and held a highly successful half-day meeting in October 2009 for local agency staff to share best practices on collaboration including strategies to improve breastfeeding support to shared clients. (IB)

The WIC Breastfeeding Consultant presented at the fall 2009 MCH Coordinators' meeting on breastfeeding resources. (PB)

MCH staff checks on documentation of WIC referral/enrollment at site visits. (IB)

The Division of Public Health Services has initiated a Breastfeeding Integration Committee to explore maximizing efforts to best accomplish mutually shared goals, especially those for overlapping client populations. (IB, PB)

The MCH Epidemiologist and his student intern are researching discrepancies between breastfeeding statistics from the birth certificate vs. the Newborn Screening Program's client information. (IB, PB)

c. Plan for the Coming Year

MCH will be working with WIC in June/July 2010 to promote August as Breastfeeding Awareness Month. (IB, PB)

At the Fall 2010 MCH Coordinators' Meeting, agency representatives will be encouraged to share ideas on what has been successful, or what obstacles they have encountered in carrying out their new workplan activities regarding encouraging breastfeeding and also encouraging enrollment in WIC. (IB)

MCH will continue to work with WIC to share educational offerings, electronic informational updates to agencies supported by MCH funds such as the community health centers, Home Visiting Program grantees, and the Child and Family Health Support service-funded agencies. (IB)

The MCH Child Health Nurse Consultant will continue to represent MCH on the NH Breastfeeding Task Force and participate in its activities. (IB, PB)

The MCH Child Health/SIDS Program Coordinator will continue to promote breastfeeding in public and professional information activities focused on SIDS risk reduction and safe sleep practices. (PB)

MCH staff will continue to check documentation of WIC referral/enrollment at site visits. (IB)

MCH will continue to participate in the Division of Public Health Services' Breastfeeding Integration Committee and others chronic disease partners in the Bureau of Population Health and Community Health Services to integrate breastfeeding and obesity prevention program initiatives. (IB, PB)

MCH and WIC will continue to jointly promote Text4Baby, a mobile phone-based health

promotion program that includes positive breastfeeding messages. MCH will continue to provide posters and tear-off information sheets for traditional partners, such as WIC programs and community health centers, as well as leverage non-traditional partners such as grocery store chains that have food contracts with WIC. MCH will also encourage continued media coverage of this program, as it grows. (PB)

MCH will utilize information from the MCH Epidemiologist and his PhD Intern/student's report on the discrepancies between reports of breastfeeding as captured on the New Hampshire birth certificate and on the newborn screening program's filter paper to explore strategies to reduce the discrepancies. (IB, PB)

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	96	97	98	99	98
Annual Indicator	96.1	97.2	98.2	97.4	97.3
Numerator	13422	13673	13683	13279	12968
Denominator	13968	14069	13937	13629	13327
Data Source				screening records	screening records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	99	99.5	99.5	99.5

Notes - 2009
Numerator is actual number of infants screened. Denominator is number of occurrent births.

Notes - 2008
Numerator is actual number of infants screened. Denominator is number of occurrent births.

Notes - 2007
Numerator is actual number of infants screened. Denominator is number of occurrent births.

a. Last Year's Accomplishments
DAILY TASKS:
The EHDI staff managed the essential tasks of providing technical assistance to birth hospitals; monitored staff performance at all newborn hearing screening programs; using birth certificate data to assure that all newborns are offered hearing screening; and assuring follow-up for all infants who do not pass their hearing screenings. (IB, PB)

SYSTEMS BUILDING:

The EHDI staff monitored the performance of all newborn hearing screening programs. Reports of the Performance Measures for calendar year 2009 were sent to the managers of all newborn hearing screening programs. (IB)

The EHDI staff monitored entries into the Auris tracking system by all newborn hearing screening personnel and audiologists at diagnostic centers, to assure compliance with recommended protocol and national standards of care. (IB)

The EHDI staff updated and distributed the guidelines for newborn hearing screening programs to all birth facility managers. (E)

The EHDI staff distributed a new DVD developed by the National Center for Hearing Assessment and Management to managers of all birth facilities. The DVD is used to train and evaluate the competency of newborn hearing screening personnel. (E)

The EHDI staff revised the brochure used to inform families about newborn hearing screening.

The EHDI Advisory Committee no longer holds face-to-face meetings. The EHDI staff provided updates about program activities by newsletters and electronic mail. (IB)

The EHDI staff discussed the requirements for development of qualified Pediatric Audiology Diagnostic Centers with several interested audiologists and organizations. (E)

The EHDI staff discussed the 2007 Joint Committee on Infant Hearing (JCIH) Guidelines for audiologic evaluations with all audiologists at diagnostic centers. (E, IB)

Audiologists at the Pediatric Audiology Diagnostic Centers distributed resource books to families of infants and young children identified as deaf or hard of hearing. (IB)

LOSS TO FOLLOW-UP:
The EHDI Program reduced loss to follow up by funding a position for someone to provide assistance and support to families of infants referred for diagnostic testing. (E)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The EHDI staff will provide technical assistance to birth hospitals, use birth certificate data to assure that all newborns have a hearing screening, and assure follow-up for every referred infants.			X	X
2. The EHDI staff will monitor staff performance and monitor quality assurance at all newborn hearing screening programs. Feedback on each facility's performance will be sent to the managers of all birth facilities annually, or more frequently, as indi				X
3. The EHDI staff will monitor the quality and content of all diagnostic test results entered in the tracking system. They will also monitor the audiologists' compliance with the 2007 Joint Committee on Infant Hearing Guidelines for audiologic evaluati				X
4. The EHDI staff will monitor the need for additional diagnostic centers in underserved areas of New Hampshire. They will continue to meet with any audiologists or facilities interested in developing a new Pediatric Audiology Diagnostic Center in the s		X		X
5. The EHDI staff will offer or refer audiologists to educational		X		X

opportunities in the local or regional settings.				
6. The EHDI staff and Family Advocate will distribute "Communicating 'Refer' Results to Families", a handout about the do's and don'ts of telling families that their infants did not pass their newborn hearing screening and conveys the need for follow-up			X	
7. The EHDI staff will develop and distribute a feedback form for all screening staff using the training DVD distributed by the National Center for Hearing Assessment and Management.				X
8. The EHDI staff and the MCH epidemiologist will develop reports to perform trend analyses for EHDI activities as soon as the New Hampshire Integrated Maternal and Child Health (MCH) Information System is available.				X
9.				
10.				

b. Current Activities

DAILY TASKS:

The EHDI staff continues to manage the essential tasks of providing technical assistance to birth hospitals; uses birth certificate data to ensure that all newborns receive a hearing screening; and assures timely follow-up for infants who need either additional hearing screenings or diagnostic evaluations. (IB, PB)

SYSTEMS BUILDING:

The EHDI staff continues to monitor staff performance at all newborn hearing screening programs. They also plan to send performance measure reports to the program managers every six months. (IB)

The EHDI staff meets with audiologists from diagnostic centers twice a year for updates, information sharing and to offer continuing education. (E)

The EHDI staff monitors the performance of audiologists at Pediatric Audiology Diagnostic Centers. The results of the most recent performance reviews were discussed at the spring audiology meeting. The EHDI staff ensures that all audiologists at diagnostic centers follow the Joint Committee on Infant Hearing (JCIH) 2007 Guidelines for audiologic evaluations. (IB)

The EHDI staff sends periodic updates about program activities to former EHDI Advisory Committee members, health professionals and other interested individuals. (IB)

LOSS TO FOLLOW-UP:

The EHDI staff monitors the use of effective quality improvement strategies when informing parents that their infant did not pass their hearing rescreen and needs diagnostic audiologic testing. (IB)

c. Plan for the Coming Year

DAILY TASKS:

The EHDI staff will continue to manage the essential tasks of providing technical assistance to birth hospitals; uses birth certificate data to assure that all newborns receive a hearing screening; and assures timely follow-up for infants who need additional hearing screenings or diagnostic evaluations. (IB, PB)

SYSTEMS BUILDING:

The EHDI staff will continue to monitor staff performance at all newborn hearing screening programs and continue to send performance measure reports to all program managers every six

months. (IB)

The EHDI staff plans to meet with audiologists from diagnostic centers twice a year for updates, information sharing and to offer continuing education. (E)

The EHDI staff plans to monitor the performance of audiologists at Pediatric Audiology Diagnostic Centers. The EHDI staff ensures that all audiologists at diagnostic centers follow the Joint Committee on Infant Hearing (JCIH) 2007 Guidelines for audiologic evaluations. (IB)

The EHDI staff plans to send periodic updates about program activities to former EHDI Advisory Committee members, health professionals and other interested individuals. (IB)

The EHDI staff and the MCH epidemiologist intend to develop reports to perform trend analyses for EHDI activities as soon as the New Hampshire Integrated Maternal and Child Health (MCH) information System is available. (IB)

LOSS TO FOLLOW-UP:
The EHDI staff plans to revise the brochure used to inform families about audiologic diagnostic testing.

The EHDI staff will assess the timeliness of appointments at Pediatric Audiology Diagnostic Centers to determine if additional testing facilities are needed in New Hampshire. (E)

The EHDI staff plans to develop and distribute a feedback form for the training DVD distributed to all newborn hearing screening program managers. (E)

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6.5	5.5	5.5	5.5	4
Annual Indicator	6.0	6.0	6.0	4.3	4.3
Numerator	18667	19402	19402	12921	12921
Denominator	311117	323309	323309	298439	298439
Data Source				2007 Nat'l Survey of Children's Health	2007 Nat'l Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	4	4	4	4	4

Notes - 2009

Data is from the 2007 National Survey of Children's Health, a project of the Child and Adolescent Health Measurement Initiative.

There are multiple sources for the uninsured population - with discrepant results. For example, the Kaiser Family Foundation Website (statehealthfacts.org) shows 5.1% uninsured children in NH. Their uninsured estimates are based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements).

We have chosen to use the number from a national survey instead of census estimates.

Notes - 2008
Data is taken from the 2007 National Survey of Children's Health, a project of the Child and Adolescent Health Measurement Initiative.

Notes - 2007
Data was obtained from the March, 2007 report, "Whose Kids are Covered, A State-by-State Look at Uninsured Children" prepared for the Robert Wood Johnson Foundation. The data comes from page 4, table 3 of the report, "Number and Percent of Children (0-18) With and Without Health Insurance Coverage in the United States, by State: Three-Year Average 2003-2005". According to the "Kids Count New Hampshire Data Book, 2008", the uninsured rate continues to be 6% (data obtained from Census estimates). Kids Count New Hampshire is based at the Children's Alliance of NH.

The Kaiser Family Foundation Website (statehealthfacts.org) show 7% for NH. Their uninsured estimates are based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).

The Behavioral Risk Factor Surveillance Survey conducted in NH in 2005-2006 may be releasing information they have gathered in the near future, regarding the percentage of children uninsured in NH. When this data is released, it will be reviewed to see how it compares with the census estimates.

a. Last Year's Accomplishments
POLICY:
According to Kaiser State Health Facts, which examined health insurance coverage of children 0 -- 18 years in every state for 2007-2008, and compared it with the U.S. numbers and rates for 2008, New Hampshire had 5.1% (16,000) children uninsured compared to the national rate of 10.3%.

MCH contracts with 14 community agencies throughout the state to provide direct child health care services to low-income, underserved children from birth through age 19. Thirteen of these are the primary care community health centers described above; one is a ‘categorical' pediatric clinic, in the state's largest urban community, which utilizes a multi-disciplinary care model. Strategically focusing efforts on access and support for low-income families, services at the child health direct care agencies include the full spectrum of family practice, such as well-child visits, immunizations, acute care visits and a spectrum of integrated behavioral and oral health services. One of the primary goals of theses health centers is to ensure that all Medicaid-eligible children are actively enrolled.

MCH ACTIVITIES:
DHHS continued its financial audits to contract agencies, with a special focus on the three new community health centers, to assure documentation of assessing and referring eligible children to the Medicaid/NH Healthy Kids Gold program. (IB)

MCH continued to monitor the Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on NH Healthy Kids and activities to enhance

Medicaid/NH Healthy Kids Gold enrollment through review of statistics and annual workplans, with a special focus on the 3 new community health centers. (IB)

MCH staff collaborated with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, policy changes and discussions about possible barriers to work on to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold through meetings, presentations, and sessions with the MCH
contract agencies. (IB)

MCH has continued to work closely with nine community agencies funded for "Child and Family Health Support Services" which includes outreach to families, schools and childcare providers, with children eligible for Healthy Kids Gold (Medicaid) or Silver (SCHIP program), assisting families with completing the Healthy Kids application, and connecting children with a medical home, through meetings, mentoring, and administrative oversight. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with NH Healthy Kids Gold, the Medicaid Program, and its State Utilization Review (SURS) unit and the NH SCHIP coordinator on any projects impacting the MCH contract agency population.				X
2. Monitor documentation of clients' financial status and efforts to enroll on Medicaid at site visits to MCH-funded community health centers.				X
3. Monitor performance measure on contract agencies' workplans on percent of eligible children enrolled on Healthy Kids Gold/Medicaid.				X
4. Monitor agency data on uninsured children.				X
5. Provide technical assistance and oversight to Child and Family Health Support funded agencies in getting eligible children enrolled on Healthy Kids Gold/Medicaid.				X
6. Provide support to new primary care grantee in Sullivan County to increase enrollment of eligible families in Healthy Kids Gold/Medicaid.				X
7.				
8.				
9.				
10.				

b. Current Activities

DHHS continues its financial audits to contract agencies to assure documentation of assessing and referring eligible children to the Medicaid/NH Healthy Kids Gold program. (IB)

MCH monitors the Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on NH Healthy Kids and activities to enhance Medicaid/NH Healthy Kids Gold enrollment through review of statistics and annual workplans. (IB)

MCH collaborates with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, policy changes and discussions about possible barriers to work on to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold through meetings, presentations, and sessions with the MCH contract
agencies. (IB)

MCH has been meeting with staff from Medicaid and Surveillance and Utilization Review Services unit to revise and update a Medicaid rule that allows MCH contract agencies to bill for education and support services, some of which are used to work with families to get eligible children enrolled on Healthy Kids Gold. (IB)

New Hampshire Family Voices and SMS Care Coordinators provide information packets with written reminders to families regarding what to bring to Medicaid Office when applying for benefits. (ES)

Special Medical Services (SMS) notes redetermination dates on annual SMS applications so care coordinators can remind parents of annual redeterminations dates. (ES)

c. Plan for the Coming Year

DHHS will continue its financial audits to contract agencies, with a special focus on its three newer community health centers, and the new Sullivan County community health center to assure documentation of assessing and referring eligible children to the Medicaid/NH Healthy Kids Gold program. (IB)

MCH will continue to monitor the Title V contract agencies' percentage of children without health insurance, percent of eligible children enrolled on NH Healthy Kids and activities to enhance Medicaid/NH Healthy Kids Gold enrollment through review of statistics and annual workplans. (IB)

MCH will continue to work closely with community agencies funded for "Child and Family Health Support Services" which includes outreach to families, schools and childcare providers, with children eligible for Healthy Kids Gold (Medicaid) or Silver (SCHIP program), assisting families with completing the Healthy Kids application, and connecting children with a medical home, through meetings, mentoring, and administrative oversight. (IB)

MCH will continue to collaborate with the NH Healthy Kids Program and the NH SCHIP Coordinator to share information, policy changes and discussions about possible barriers to work on to increase enrollment of uninsured eligible children on Medicaid/Healthy Kids Gold through meetings, presentations, and sessions with the MCH contract agencies. (IB)

MCH will work with Medicaid and its SURS (Surveillance and Utilization Review Services) unit to offer a half-day training on the revised Medicaid rule that allows MCH contract agencies to bill for education and support services, some of which are used to work with families to get eligible children enrolled on Healthy Kids Gold. (IB)

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		35	35	33	32
Annual Indicator	35.0	34.0	33.6	32.5	32.2
Numerator	2274	2381	2437	2691	2886
Denominator	6496	7003	7254	8286	8963
Data Source				NH WIC program	NH WIC Program
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	31	30	29	28	27

Notes - 2009
Data is from Lisa Richards, NH WIC program, from CDC Pediatric Nutrition Surveillance System.

Notes - 2008
Data is from Lisa Richards, NH WIC program, from CDC Pediatric Nutrition Surveillance System.

Notes - 2007
Data is from Lisa Richards, NH WIC program, from CDC Pediatric Nutrition Surveillance System.

a. Last Year's Accomplishments
POLICY
A legislatively created NH Commission on the Prevention of Childhood Obesity was convened by the Governor's Office. The Commission's goal is to identify and consider legislative and policy strategies that may be effective in the prevention of childhood obesity, and to seek input from appropriate individuals and organizations.

NH is in the second year of a five-year CDC Obesity Prevention grant that funds the state's Obesity Prevention Program. Target areas of the program include: increasing breastfeeding initiation, duration, and exclusivity; increasing physical activity; increasing consumption of fruits and vegetables; decreasing consumption of sugar sweetened beverages; decreasing consumption of energy dense foods and decreasing television viewing.

MCH ACTIVITIES:

The Oral Health Program collaborated with Dr. Sherry Buerrer, CDC EIS Officer, and the DPHS Chronic Disease Epidemiologist and the Nutrition and Health Promotion program to analyze and report on data collected on 4,500 third grade students in 81 randomly selected NH schools to provide the first county level information on the oral health and BMI status of NH children. (IB)

The MCH Healthy Child Care NH Project Coordinator collaborated with the state Obesity Prevention Program to include obesity prevention as a component of health for children enrolled in child care programs. The Child Care Health Consultant Coordinator worked with childcare programs to address environment (increasing physical activity, decreasing TV time and increasing access to healthy foods) policy changes that will prevent obesity. (IB)

As part of its quality assurance efforts, MCH continued to monitor the activities of the community health centers' use of BMI and BMI percentile documentation at site visits. MCH staff also reviewed workplan activities and results relative to a BMI performance measure required by MCH of its community health centers since FY08. (IB)

The MCH Child Health Nurse Consultant represented NH DHHS on an Advisory Board to a rural community health center that received a Healthy Tomorrows AAP/MCHB grant pediatric obesity. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to monitor the documentation and graphing of BMI results in paper and electronic charts as part of the MCH quality assurance site visit and review of agency workplans.				X
2. Continue to collaborate with WIC in sharing any educational information on preventing and reducing childhood obesity with MCH contract agencies.			X	X
3. Continue to participate in any statewide obesity prevention and control activities representing the NH DHHS.				X
4. Participate in any state obesity prevention grant activities and committees as appropriate.			X	X
5. The MCH Child Health Nurse Consultant will continue to represent NH DHHS on the Advisory Committee for the Healthy Tomorrows AAP/MCHB –funded pediatric obesity project in the northern community health agency.				X
6. Continue promotion of Healthy NH 5-2-1-0 Plan with providers and families encouraging increasing fruits and vegetables and exercise while decreasing screen time and sugar-filled beverages.			X	
7.				
8.				
9.				
10.				

b. Current Activities

MCH participates in activities related to the CDC Obesity Prevention grant as they develop. (IB, PB)

MCH monitors BMI use by the community health centers through site visits and workplan review. (IB)

MCH encourages use of the pediatric obesity -- related 5-2-1-0 Healthy NH program with its contract agencies. (IB, PB)

The MCH Child Health Nurse Consultant represents NH DHHS on the Advisory Board of the Healthy Tomorrows AAP/MCHB funded pediatric obesity program at one of the northern community health centers. (IB)

The Oral Health Program and the Nutrition and Health Promotion program released its report, Third-Grade Healthy Smiles-Healthy Growth Oral Health-BMI (Body Mass Index) in December 2009. (IB)

MCH and WIC assessed local collaboration by its local community agencies in summer 2009 and held a highly successful half-day meeting in October for local agency staff to share best practices on collaboration including strategies to improve growth measurements and obesity prevention education for mutual clients. (IB)

POLICY:
The Child Health Nurse Consultant participates in any statewide obesity prevention and control activities representing the NH DHHS. (IB)

MCH participates in action steps, as appropriate, from the New Hampshire HEAL (Healthy Eating Active Living) Action Plan, a blueprint for statewide efforts to assist residents in adopting and

maintaining a healthy weight. (IB, PB)

c. Plan for the Coming Year
MCH will participate in activities related to the CDC Obesity Prevention grant as they develop. (IB, PB)

MCH will continue to monitor the activities of the community health centers pertaining to documenting and graphing BMI, and age and gender-appropriate BMI percentiles. This will be done as part of MCH's quality assurance site visits to the state-funded community health centers, and through reviews of past, current, and proposed workplan activities. (IB)

MCH will explore changing its BMI-related performance measure from one of monitoring measurement documentation to one exploring use of the BMI/BMI percentile to track health/weight status and educate families regarding healthy lifestyle. (IB)

The MCH Child Health Nurse Consultant will continue to represent NH DHHS on an Advisory Board at one of the northern community health centers that received a Healthy Tomorrows AAP/MCHB grant focusing on pediatric obesity. (IB)

MCH will continue to share information electronically with MCH-funded agencies on new initiatives, research, educational material, or suggestions for working with families to prevent or reduce pediatric obesity. (IB, PB)

At the Fall 2010 MCH Coordinators' Meeting, agency representatives will be encouraged to share ideas on what has been successful, or what obstacles they have encountered in carrying out their workplan activities regarding WIC enrollment of eligible children, and on use of the BMI/BMI percentile. There will be a special focus on successful strategies in talking to families about preventing or decreasing pediatric obesity and promoting a healthy lifestyle. (IB)

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12	12	13	12
Annual Indicator	12.3	12.7	13.3	12.0	12.0
Numerator	1511	1599	1681	1627	1627
Denominator	12246	12605	12621	13606	13606
Data Source				Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	11.5	11	10.5	10	9.5

Notes - 2009
Data is not available. 2008 data is used as an estimate.

Notes - 2007
Data does not include out-of-state births, as they are not available.

a. Last Year's Accomplishments
QUALITY ASSURANCE:
MCH continued to monitor and evaluate clinical interventions for smoking cessation throughout pregnancy through community health centers, prenatal agencies, and Home Visiting New Hampshire's performance measures. (IB)

The MCH Epidemiologist continued the developmental phase of the analysis of birth outcomes by using the Prenatal Health Care Index (PHCI), . The PHCI is an outcome index based on preventable maternal and neonatal hospitalizations. (IB)

COLLABORATION AND SYSTEMS BUILDING:
MCH worked with the New Hampshire Tobacco Control Program to plan for further integration of smoking cessation and the new Public Health Service Guidelines into primary and prenatal care. (PB, ES, IB)

The Prenatal Program worked with the Bureau of Drug and Alcohol Services to try to allow pregnant women to gain priority at drug treatment facilities. This is still in process. (ES, PB)

The Women's Health Committee, in collaboration with the New Hampshire Tobacco Control Program, received funding from the CDC to provide intensive tobacco cessation education for staff at the Manchester Community Health Center, one of MCH's funded health centers. A baseline query on smoking among patient of childbearing age was done. The Tobacco Prevention and Control Program also presented a series of lunch and learn trainings to community health centers and other primary care and perinatal providers on tobacco cessation counseling. (PB, IB)

The Home Visiting Program facilitated a training session on smoking cessation and referral at one of their quarterly meetings. (PB, IB)

The Prenatal Coordinator resigned in the summer of 2009 after an extended maternity leave. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitor and evaluate MCH contract agencies' clinical interventions around smoking, including performance indicator.				X
2. Fully implement web-based Perinatal Client Data Form (PCDF) data system and generate reports for all MCH-funded prenatal agencies.				X
3. Determine availability of data linkage projects such as the birth certificate and hospital discharge data. Generate reports based on this data.				X
4. Aggressively market and promote the NH Smokers' Helpline and www.trytostopnh.org to providers and ultimately to smokers of reproductive age.		X	X	X

5. Coordinate training efforts with the NH DPHS Tobacco Prevention and Control Program.				X
6. Continue analysis of birth outcomes by using the Prenatal Health Care Index (PHCI).				X
7.				
8.				
9.				
10.				

b. Current Activities

QUALITY ASSURANCE:

The MCH Epidemiologist is continuing his analysis of birth outcomes by using the Prenatal Health Care Index (PHCI). The PHCI is an outcome index based on preventable maternal and neonatal hospitalizations. Because smoking among pregnant women is relatively high in NH, it is anticipated that analyses will help identify opportunities for intervention. (IB)

MCH continues to monitor clinical interventions for smoking cessation throughout pregnancy through community health center and prenatal agencies performance measures. (IB)

Comparison data from the PCDF was presented at the Spring 2010 MCH Directors' meeting. Agencies were given numbers privately identifying their own agency while comparisons on different measures were shown onscreen. A hard copy data report, with earlier data, had been sent in the fall of 2009. (IB)

The linkage between birth datasets, maternal discharges and birth certificates (by social security numbers), was recently approved and received for analysis. The MCH Epidemiologist will utilize these linked datasets to address birth outcome disparities among hospital service areas. Analyses that are being worked on include, but are not limited to induction of labor, elective cesarean section, and maternal mortality. (IB)

COLLABORATION AND SYSTEMS BUILDING:

MCH helps to market the Quitline to clinical providers throughout the state. (IB, ES, PB)

c. Plan for the Coming Year

QUALITY ASSURANCE:

MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women with particular attention to performance indicator on prenatal tobacco screening and referral. (DS, ES, IB)

The linkage project ensures that contract agency prenatal and birth data are available to providers for quality improvement purposes as well as to inform public health policy in maternal and child health. Problems are still being worked out in terms of linking the birth certificate and PCDF. The data contractor's matching algorithm needs work to increase the percentage of birth certificates and PCDF data linked. After this is completed, MCH is planning a meeting with the prenatal agencies to review their reporting needs, which will assist in developing future improvements to the system. (IB)

The MCH data team is developing a quality improvement plan for the prenatal data linkage project including collection, analysis, and reporting measures. (IB)

There continues to be a problem with those patients (approximately 10%) who deliver out of state. The prenatal care information (including entry) is recorded differently making it not comparable between birth certificates. This is making population assessment difficult. The MCH

Epidemiologist is waiting for other states to adopt the 2003 revised birth certificate making population based data for the state accessible. (IB)

COLLABORATION AND SYSTEMS BUILDING:
MCH will continue to work with the Tobacco Control Program to facilitate another training for the rest of Manchester Community Health Center's staff on tobacco screening and referral as well as a second data query run. (PB, IB)

The Home Visiting New Hampshire Program is investigating creating a web-based training on smoking cessation for all Home Visiting New Hampshire program contracts with MCH (IB).

MCH will be working with the Tobacco Prevention and Control Program on a potential request for proposals from MCH's funded primary care centers to obtain nicotine reduction therapy (NRT) as a method of cessation to offer to patients. This would be in addition to recommending the Quitline. (DS, ES)

The Tobacco Prevention and Control Program and MCH will continue to work with several of MCH's funded primary care centers in a multi-state learning collaborative on tobacco screening, referral, and cessation methods. (PB, IB)

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	138	130	102	30	0
Annual Indicator	63.7		5.1	3	3
Numerator			5		
Denominator			98207		
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2	2	1	1	0

Notes - 2009
Starting with the year 2005, NH is using the following document as guidance for injury data: Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in Boston in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Notes - 2008
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in Boston in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events AND when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Notes - 2007
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in Boston in August of 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events AND when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

a. Last Year's Accomplishments
Adolescent Health:
The Adolescent Health Program continued to promote integrated universal behavioral health and substance abuse screening in preventive health visits in MCH-funded adolescent and community health centers during quality assurance site visits, performance measures, and technical assistance. (IB)

A new performance indicator on encouraging annual adolescent visits, which includes behavioral health screenings, was added to the clinical primary care indicators, for the MCH funded community health centers. This had been in existence for the one MCH funded adolescent health center, but was extended to include adolescents at all funded sites. (IB)

Suicide Prevention Council (SPC):
The Injury Prevention Manager continued to co-chair the Communications Subcommittee of the SPC. Presentations on the media guidelines for reporting on suicides were part of the Advanced Journalism classes at the University of New Hampshire for the second consecutive year and are now embedded into the curriculum. This included two sessions, which took place in April of 2009. A fifty percent increase on knowledge of media guidelines was maintained through a pre and posttest survey. This year writing exercises were incorporated into the lesson plan. Some of the comments included: "Editing exercise helped show us what you mean rather than telling us"; "Cautious discretion when reporting", and "Interesting to learn our writing really affects people". (PB, IB)

The SPC Communications Subcommittee also continued its monitoring of statewide media outlets' reporting of occurring suicides and adherence to the guidelines. The Subcommittee wrote response letters to the media where appropriate. (PB, IB)

For Suicide Prevention Month, a screening and facilitated discussion of the film "Ordinary People" took place, a film focusing on the aftermath of the suicide attempt of an adolescent. Most of the

people attending found it "worthwhile" according to the post-film survey and several were added to the suicide prevention list serve. (PB)

The SPC Communications Subcommittee wrote and got funded a grant with the New Hampshire Humanities Council to facilitate a series of two film screenings in Portsmouth and Derry entitled "A Discourse on Suicide Through Film". This would allow the hiring of a "humanist" or doctoral level professional in humanities to facilitate post-screening discussions on both "Ordinary People" and the film, "Sensation of Sight (SOS)", also focusing on an adolescent suicide and its aftermath. The latter was filmed in New Hampshire several years ago so the Subcommittee was able to speak with both the director and producer who agreed to participate in the project. (PB)

The Adolescent Health Program Coordinator continued to co-chair the Data Subcommittee of the SPC and YSPA until her resignation in early 09. The annual suicide data report expanded to include military and corrections data. The recommendations to optimize data were integrated into the newly revised SPC statewide suicide prevention plan and implemented into the Subcommittee's action plans. (IB)

The SPC and its subcommittees revised the state suicide prevention plan and released it to the public during Suicide Prevention Month in September. A press conference was held, which garnered all of the major media outlets in the state. Immediately following the press conference, a recognition ceremony took place where the Maternal and Child Health Section's Injury Prevention and Adolescent Health Program Manager received a citation from the Governor, thanking her for her commitment and efforts on behalf of suicide prevention efforts in the state. A "Call to Action" was held on the same day where all five subcommittees of the SPC broke into groups inviting the public to comment on the newly revised suicide prevention plan. (PB, IB)

Youth Suicide Prevention Assembly (YSPA):
The Maternal and Child Health Section continued its active involvement on YSPA by participating in monthly meetings (IB). YSPA revisited the best methods to impact local change and held planning sessions with local coalitions, including one on the Seacoast. The Seacoast Suicide Prevention Coalition (based in Portsmouth, New Hampshire) was able to get funding and has operated with the help of YSPA for close to a year. Its achievement was the placement of signs highlighting the national suicide prevention number on area bridges (of which several were the site of recent suicide attempts). (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to monitor MCH-funded adolescent health programs and community health centers on appropriate screening tools and the new clinical performance measure/ indicator regarding screening.				X
2. Work with state partners, the Suicide Prevention Committee (SPC), and the various subcommittees to implement the Statewide Suicide Prevention Plan.				X
3. Chair the Communications Subcommittee of the SPC and work on its activities in the newly revised plan.				X
4. Facilitate classes university-based journalism students on the guidelines for the reporting of suicide.			X	
5. Conduct “A Discourse on Suicide Through Film” funded through the New Hampshire Humanities Council.			X	
6. Secure funding for ongoing planning and implementation of suicide prevention training and education activities.				X

7. Represent MCH on Youth Suicide Prevention Assembly (YSPA).				X
8. Collaborate with YSPA and SPC on their joint annual conference.				X
9.				
10.				

b. Current Activities

Suicide Prevention Council (SPC):
The Communications Subcommittee of the SPC presented to the staff of Keene State College's student newspaper the "Equinox" in February of 2010. The presentation focused on the guidelines for the media reporting of suicide. Presentations at Keene State take place on an every other year basis and will continue to do so. Sixty six percent of the student staff increased their knowledge on reporting guidelines between a pre and post- test survey. Comments included, "Great presentation" and "Really effective editing exercise". (PB, IB)

The Communications Subcommittee also facilitated "A Discourse on Suicide Through Film", a two-part film series and discussion that took place at the Derry Public Library in Derry and the Community Campus in Portsmouth in March and May of 2010. Maren Tirabassi, Ph.D., facilitated the post-film discussions. (PB)

The Injury Prevention and Adolescent Health Program Manager presented at the annual conference of the American Association of Suicidology in late April of 2010. Her presentation was entitled, "Promoting Responsible Reporting on Suicide in Communities by Engaging Journalism Students in a Workshop on Ethics and Use of Media Recommendations". (PB, IB)

Youth Suicide Prevention Assembly (YSPA):
YSPA held its annual conference in conjunction with the SPC. Participants increased their knowledge of suicide prevention by 26% in a pre and post-conference survey. (PB, IB)

c. Plan for the Coming Year

Guided by the New Hampshire Suicide Prevention Plan, MCH will continue its efforts in reducing the rate of suicide deaths through strategic partnerships with community based practitioners, advocacy, education, and policy development. (PB, IB)

Adolescent Health:
The Adolescent Health Program will continue to gather data and provide technical assistance to community health centers on the new performance indicator encouraging annual health visits for adolescents. (IB)

Suicide Prevention Council (SPC):
The Injury Prevention Program will continue to chair the Communications Subcommittee of the Suicide Prevention Council, which meets monthly. The goal of the Subcommittee for the next year is to implement at least 75% goals and objectives of the recently revised communications section of the New Hampshire State Suicide Prevention Plan. (IB)

One of the first tasks for this next year is to write up a summation of the New Hampshire Humanities Council Project, "A Discourse on Suicide Through Film". This will enable the Subcommittee to assess how the program worked, its outcomes, and future steps. (IB)

The producer and executive director of "Sensation of Sight" want to collaborate to continue a similarly designed project bringing a series of films on suicide/suicide prevention to already existing film festival locations. In addition, the American Association of Suicidology Conference,

the Injury Prevention Program Manager met several colleagues who have written a book and blog about the portrayal of mental illness, and in particular suicide, in film. These colleagues also want to work with the SPC Subcommittee on a potential project. Merging the two together will be a focus of upcoming meetings. (PB, IB)

The SPC's Communications Subcommittee will continue to facilitate classes in advanced journalism on an annual basis to University of New Hampshire students and every other year to student staff of Keene State College's "Equinox". The classes will focus on the reporting of suicides according to the media guidelines developed in 2001 by the Centers for Disease Control and Prevention, National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology, and the Annenberg Public Policy Center. (PB)

This upcoming year, the Subcommittee will try to introduce and present these same classes to the Communications majors at Franklin Pierce University, who are focusing on journalism. The three institutions of learning, the University of New Hampshire, Keene State College, and Franklin Pierce University are the only ones in the state who provide professional training in journalism as a major. (PB)

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	86	79	89
Annual Indicator	78.7	85.3	78.0	87.5	87.5
Numerator	107	110	92	91	91
Denominator	136	129	118	104	104
Data Source				Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	91	92	93	94

Notes - 2009
Data is unavailable. Data from 2008 is used an estimate.

Notes - 2007
Data is for resident occurrent births. Out-of-state data is not available for 2007.

a. Last Year's Accomplishments
QUALITY ASSURANCE:
The MCH Epidemiologist continued his analysis of birth outcomes by using the Prenatal Health Care Index (PHCI), which is really still in a developmental phase. The PHCI is an outcome index based on preventable maternal and neonatal hospitalizations. (IB)

The MCH Epidemiologist investigated trends among very low birth weight infants delivered at facilities for high-risk deliveries and neonates including further exploration of birth data for the 11-12% of New Hampshire infants delivered at out of state hospitals. In one county of the state, approximately 29% of all births are out of state deliveries. There continued to be a problem, however, in linking birth certificates with those patients who deliver out of state. The prenatal care information is recorded differently making it not comparable between birth certificates. Thus making population assessment difficult. (IB)

The MCH Epidemiologist also looked at rates of elective cesarean sections by hospital service area. He was hoping to birth certificates with hospital discharge data, but that linkage was still in process. Thus, he utilized only birth certificates. This showed high rates of cesareans between hospitals and even amongst hospital providers. Further study is warranted. (IB)

A bill was introduced to establish a maternal mortality review committee within the state. The Maternal and Child Health Section was involved in both developing the language and supporting this bill which passed the House and Senate and is awaiting the Governor's signature. In preparation to present information for the bill, the MCH Epidemiologist looked at maternal mortality rates from both the birth and death certificates and is awaiting the linkage with hospital discharge data.
(IB)

MCH continued to monitor and provide technical assistance to its funded prenatal and primary care agencies that provide comprehensive care to low income, uninsured and underinsured pregnant women. (DS, ES, IB)

SYSTEMS DEVELOPMENT:
The Prenatal Program Coordinator worked with the March of Dimes to identify ways to reduce or prevent prematurity. (IB, PB)

The web-based Auris Perinatal Client Data Form (PCDF) linkage system, successfully implemented in FY08, contains 2007 (July-December) and 2008 data. Staff continued to work with the vendor and with the agencies to improve the PCDF system so that it met the needs of MCH and the agencies. (IB)

The Prenatal Coordinator resigned in the summer of 2009 after an extended maternity leave. (IB)

MCH facilitated Prenatal Coordinators' meetings continued on a biannual basis. Presentations included those from staff of WIC, Tobacco Prevention and Control Program, and Immunization. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participate on the March of Dimes Program Planning Committee to ensure statewide efforts for improving birth outcomes are coordinated.			X	X
2. Facilitate biannual meetings of the Prenatal Coordinators from MCH-funded agencies to inform them of best practices, infrastructure developments, and quality improvement activities.				X
3. Participate in the biannual statewide Perinatal Nurse Managers meeting to discuss topics such as appropriate transfer and transport.			X	X
4. Implement data linkage projects with the Perinatal Client Data				X

Form (PCDF), birth certificate and hospital discharge data. Generate reports based on this data.				
5. Provide technical assistance and monitor prenatal care at MCH contract agencies.				X
6. Develop rules for and participate in the newly formed Maternal Mortality Review Committee. (IB)				
7.				
8.				
9.				
10.				

b. Current Activities

QUALITY ASSURANCE:

MCH continues to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

Comparison data from the PCDF was presented at the Spring 2010 MCH Directors' meeting. Agencies were given numbers privately identifying their own agency while comparisons on different measures were shown onscreen. A hard copy data report, with earlier data, had been sent in the fall of 2009. (IB)

The linkage between birth datasets, maternal discharges and birth certificates was recently approved and received for analysis. The MCH Epidemiologist will utilize these linked datasets to address birth outcome disparities among hospital service areas. Analyses that are being worked on include, induction of labor, elective
cesarean section, and maternal mortality. (IB)

The MCH Epidemiologist is part of the Northern New England Perinatal Quality Indicators Network (NEPQIN), based at Dartmouth Hitchcock Medical Center. They are attempting to obtain AHRQ status. (IB)

MCH monitored and provided technical assistance for legislation to enact a Maternal Mortality Review Panel that was ultimately passed. (IB)

SYSTEMS DEVELOPMENT:

MCH will participate in the Perinatal Nurse Managers meeting hosted by the Perinatal Outreach Nurse at Dartmouth Hitchcock Medical Center. (IB)

MCH continues to work with the NH March of Dimes to promote systems development. (IB)

c. Plan for the Coming Year

QUALITY ASSURANCE:

MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. (DS, ES, IB)

The linkage project ensures that contract agency prenatal and birth data are available to providers for quality improvement purposes as well as to inform public health policy in maternal and child health. Problems are still being worked out in terms of linking the birth certificate and PCDF. The data contractor's matching
algorithm needs work to increase the percentage of birth certificates and PCDF data linked. After this is completed, MCH is planning a meeting with the prenatal agencies to review their reporting needs, which will assist in developing future improvements to the system. (IB)

The MCH data team is developing a quality improvement plan for the prenatal data linkage project including collection, analysis, and reporting measures. (IB)

There continues to be a data capture problem with those patients (approximately 10%) who deliver out of state. The prenatal care information (including entry) is recorded differently making it not comparable between birth certificates. This is making population assessment difficult. The MCH Epidemiologist is waiting for other states to adopt the 2003 revised birth certificate making population based data for the state accessible. (IB)

The MCH Epidemiologist will analyze the linked data sets, birth certificates and maternal discharge data, in order to produce reports on infant readmission within 30 days and maternal readmission within 30 days. (IB)

MCH staff will participate in the newly formed and legislated maternal mortality review committee. (IB)

SYSTEMS DEVELOPMENT:
MCH will continue to facilitate Prenatal Coordinators' meetings on a biannual basis. (IB, PB)

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	85	82	83	84
Annual Indicator	83.4	81.5	82.0	82.7	82.7
Numerator	9251	8980	9233	8960	8960
Denominator	11095	11015	11263	10837	10837
Data Source				Birth Certificate	Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	84	85	86	87	88

Notes - 2009
Data is unavailable. Data from 2008 is used as an estimate.

Notes - 2008
Birth records that did not have information for this measure were not included in the denominator.

Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is no longer explicitly collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began, by subtracting the date of the last menses.

Notes - 2007
1425 birth records did not have information for this measure, and were not included in the denominator.

Out-of-state birth data is not available.

Data is not comparable to years prior to 2005, due to the fact that the month prenatal care began is no longer explicitly collected after 2004. Instead, we collect the date of the first prenatal care visit and calculate the month of pregnancy in which prenatal care began, by subtracting the date of the last menses.

a. Last Year's Accomplishments
MCH continued to monitor and provide technical assistance to its funded prenatal and primary care agencies that provide comprehensive care to low income, uninsured and underinsured pregnant women. (DS, ES, IB)

MCH continued to work with the Medicaid Program and the "Enhanced Care Coordination" project to increase utilization of services, increase quality and satisfaction of services and to improve birth outcomes. (PB, ES)

There continues to be a problem in linking birth certificates with those patients (approximately 10%) who deliver out of state. The prenatal care information is recorded differently making it not comparable between birth certificates. Thus making population assessment difficult. (IB)

The web-based Auris Perinatal Client Data Form (PCDF) linkage system, successfully implemented in FY08, contains 2007 (July-December) and 2008 data. Staff continued to work with the vendor and with the agencies to improve the PCDF system so that it met the needs of MCH and the agencies. (IB)

SYSTEMS DEVELOPMENT:
MCH facilitated Prenatal Coordinators' meetings continued on a biannual basis. Presentations included those from staff of WIC, Tobacco Prevention/Cessation, and Immunization. (IB)

The Prenatal Coordinator continued to serve on the Program Planning Committee of the New Hampshire March of Dimes to ensure that efforts for improving birth outcomes are linked. (IB)

The Prenatal Coordinator resigned in summer of 2009 after an extended maternity leave. Due to state budget reductions, personnel freezes, and organizational re-alignments, MCH has been temporarily unable to fill this position. (IB)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate on the March of Dimes Program Planning Committee to ensure statewide efforts for improving birth outcomes are coordinated.				X
2. Facilitate biannual meetings of the Prenatal Coordinators from MCH-funded agencies to inform them of best practices, infrastructure developments, and quality improvement activities.				X
3. Provide technical assistance and monitor prenatal care and access at MCH contract agencies.				X
4. Gather and disseminate information in integrating life course health development both within MCH as a whole and family				X

planning.				
5. Implement data linkage projects with the Perinatal Client Data Form (PCDF), birth certificate and hospital discharge data. Generate reports based on this data.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

QUALITY ASSURANCE:

MCH continues to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. Analysis and trending of the first prenatal performance measure, which looks at entry into care within the first trimester, is a priority. (DS, ES, IB)

Comparison data from the PCDF was presented at the Spring 2010 MCH Directors' meeting. This included entry in care within the first trimester. Agencies were given numbers privately identifying their own agency while comparisons on different measures were shown onscreen. A hard copy data report, with earlier data, had been sent in the fall of 2009. (IB)

SYSTEMS DEVELOPMENT:

The MCH Title V Director is developing a plan on how to integrate the life course perspective into MCH by participating in workshops sponsored by the Boston University School of Public Health, Department of Public Health and the Knowledge to Practice Work Group. (IB)

The Family Planning Program Manager is currently supervising a master's level intern who is investigating the integration of the lifecourse perspective into family planning. The goal of this endeavor will be to increase the number of men and women, who have a reproductive life plan which, will ultimately increase the number of women who enter prenatal care in the first trimester. It will also form the basis of a future adolescent pregnancy prevention grant proposal. (IB)

c. Plan for the Coming Year

MCH will continue to monitor and provide technical assistance to MCH-funded prenatal and primary care agencies that provide comprehensive prenatal care to low income, uninsured and underinsured women. Analysis and trending of the first prenatal performance measure, which looks at entry into care within the first trimester, will continue to be a priority. Special emphasis this next year will focus on those agencies with a low percentage of women coming into first trimester care. However, NH's Title V state agency capacity continues to be challenged by this priority, due to the lack of a dedicated perinatal program manager. (DS, ES, IB)

The linkage project ensures that contract agency prenatal and birth data are available to providers for quality improvement purposes as well as to inform public health policy in maternal and child health. Problems are still being worked out in terms of linking the birth certificate and PCDF. The data contractor's matching algorithm needs work to increase the percentage of birth certificates and PCDF data linked. After this is completed, MCH is planning a meeting with the prenatal agencies to review their reporting needs, which will assist in developing future improvements to the system. (IB)

The MCH data team is developing a quality improvement plan for the prenatal data linkage project including collection, analysis, and reporting measures. (IB)

There continues to be a problem with those patients (approximately 10%) who deliver out of state. The prenatal care information (including entry) is recorded differently making it not comparable between birth certificates. This is making population assessment difficult. The MCH Epidemiologist is waiting for other states to adopt the 2003 revised birth certificate making population based data for the state accessible. (IB)

SYSTEMS DEVELOPMENT:
MCH staff will continue to participate on the March of Dimes Program Planning Committee to ensure the efforts for improving birth outcomes are linked. (IB)

Program Managers are participating in the Office of Minority Health's survey of prenatal providers in the Manchester and Concord areas of the state. Surveys encompass the needs of the refugee and immigrant population and will be focusing on access into care. (IB)

MCH staff also will continue to be involved in the Perinatal Depression Collaborative. This is a group of professionals interested in the screening and treatment of depression in women in the perinatal period. (IB)

D. State Performance Measures

State Performance Measure 1: *Percent of data linkage projects completed*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		40	60	80	100
Annual Indicator		60.0	80.0	80.0	80.0
Numerator		3	4	4	4
Denominator		5	5	5	5
Data Source				MCH Data Team	MCH Data Team
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	

Notes - 2008
The Medicaid program has recently issued a contract to do linkage with the birth certificate.

Notes - 2007
The infant birth, and Maternal and Child Health Section prenatal care link was achieved in CY 2007.

a. Last Year's Accomplishments
MCH continues to work with the Department of Information Technology (DoIT), formerly the Office of Information Technology (OIT), to develop new linkages and maintain and improve existing ones.

OVERALL DATA LINKAGE PLAN:
Continue to develop policies and procedures for the NSP, PCDF, and EHDI linkages and for access to the MCH Data Mart (IB)

Continue to improve access to timely and accurate data for both internal (DHHS) and external

users (e.g. MCHS funded community health agencies) (IB)

MCH DATA MART:
MCH is dependant on DoIT to develop the MCH Data Mart; reassignment of OIT staff resulted in a delay in the timeline to complete this project. Development has been approved to begin in June 2009. Plans include expanding the MCH Data Mart to include linked data from Auris. (IB)

As part of MCH Data Mart activities, MCH is developing a Memorandum of Understanding (MOU) between Title V and NH Medicaid that will include detailed plans and commitments for data sharing. (IB)

PERINATAL CLIENT DATA FORM LINKAGES:
MCH continues to make enhancements to the PCDF including the development of reporting capabilities for both the PN agencies and the MCH, improvement of the error reporting interface and others.

MCH continues to provide training and technical assistance to prenatal agencies and CHCs, as needed, as they implement the new reporting system. (IB)

AURIS DATA LINKAGES:

MCH continues to provide training and technical assistance to new birth facility staff and audiologists as they utilize the system.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand the MCH Data Mart to include in Phase I, a data feed from Auris that contains EHDI, PCDF, BCP, UMASS NSP and additional data from Vital Records (NHVRIN).				X
2. Expand the MCH Data Mart to include in Phase II, additional data from UMASS: specimen data and test results data.				X
3. Work with DoIT, DVRA, WIC, Medicaid to plan and implement data feeds to the MCH Data Mart in subsequent phases.				X
4. Continue to develop policies and procedures for the NSP, PCDF, and EHDI linkages and for access to the MCH Data Mart .				X
5. Continue to improve access to timely and accurate data for both internal (DHHS) and external users (e.g. MCHS funded community health agencies).				X
6. Continue to make enhancements to the PCDF including further development of reporting capabilities for both the PN agencies and the MCH, improvement of the error reporting interface and others.				X
7. Continue to provide training and technical assistance to prenatal agencies and CHCs, as needed, as they implemented the new reporting system.				X
8. Continue to provide training and technical assistance to new birth facility staff and audiologists as they begin to report new born hearing results.				X
9.				
10.				

b. Current Activities

MCH will continue the development of an integrated system of linked data sets that will fulfill several critical public health functions: identification of infants not screened for hearing and metabolic disorders, identification of disparities among the prenatal population receiving MCHS-funded community-based services and among other MCH populations in the state, and evaluation of the effectiveness and accessibility of health services provided by the MCH.

FY09 Phase I plans, which include expanding the MCH Data Mart to include linked data from Auris, will continue into FY10. With continued support from HRSA SSDI, MCH will continue development of data linkages in Phase II and Phase III focusing on Death data, Medicaid data and WIC data in years 2010-2011.

PERINATAL CLIENT DATA FORM LINKAGES:
MCH continues to make enhancements to the PCDF including further development of reporting capabilities for both the PN agencies and the MCH, improvement of the error reporting interface and others. (IB)

MCH has provided training and technical assistance to prenatal agencies and CHCs, as needed, as they implemented the new reporting system. (IB)

AURIS (HEARING SCREENING) DATA LINKAGES:

MCH has provided training and technical assistance to new birth facility staff and audiologists as they begin to report (IB)

c. Plan for the Coming Year
Because MCH has reached its goal for this performance measure, other priorities have taken precedence and it will be discontinued in FY 2011.

MCH will continue to monitor data linkage activities and will incorporate the MCH Data Mart functions into broader DPHS Health Information Infrastructure as well as support MCH Data improvements with new Home Visiting funding.

State Performance Measure 3: *Percent of children age two (24-35 months) on Medicaid who have been tested for lead.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	27	27	28	34	35
Annual Indicator	31.7	27.4	33.8	32.6	42.2
Numerator	1507	1316	1618	1646	1473
Denominator	4751	4801	4780	5042	3489
Data Source				Child Lead Prog.	Child Lead Prog.
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	36	37	38	39	

Notes - 2009
Calendar year 2009 data from Paul Lakevicius, Childhood Lead Prevention Program.

Notes - 2008
Calendar year 2008 data from Megan Tehan, Childhood Lead Prevention Program.

Notes - 2007
Calendar year 2007 data from Megan Tehan, CLPPP.

a. Last Year's Accomplishments
SURVEILLANCE AND DATA ANALYSIS:
The Way Home, Inc. completed a grant from the CLPPP to provide lead poisoning prevention and management workshops for childcare providers, healthcare providers and other professionals, focusing on screening guidelines, and provide guidelines to homeowners and families in Franklin, NH. (PB, IB)

The CLPPP is beginning collaboration with Medicaid to implement the 2008 Healthcare Effectiveness Data and Information Set (HEDIS). (IB)

The CLPPP continued to cross-matching Medicaid enrollment records with the lead test database to identify screening status. (IB)

The CLPPP continued to contact health care providers to advise confirmatory testing within recommended timeframes in the Screening Guidelines. (IB)

The CLPPP invited Dr. Michael Shannon, chair of Pediatrics at Harvard Medical School, to speak at an educational session for health care professionals regarding screening and management of blood lead levels in children. (PB, IB)

The CLPPP implemented recommendations documented by the legislatively mandated study commission in its November 2008 final report to improve screening rates and increase the number of lead safe homes for families. (PB, IB)

The CLPPP trained critical partners to facilitate the dissemination of lead poisoning prevention education and healthy homes information. (IB)

The CLPPP staff provided training on preventing lead poisoning to prenatal and child health coordinators, MCH Home Visiting agencies and HCCNH child care health consultants. (IB)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CLPPP staff will continue to attend MCH Coordinators' Meetings to share information updates with Title V funded Child Health and Primary Care.				X
2. The 14 state-funded primary care agencies will continue to have lead screening of at risk 2 year olds as a required performance measure for their contract workplans.			X	X
3. MCH will continue to monitor lead screening activities in its MCH-funded primary care agencies by chart audits at site visits, and oversight of agency annual workplans which include a performance measures on screening of 2 year olds.				X
4. The CLPPP will continue to facilitate and provide TA to Local Lead Action and Healthy Homes Committees in highest risk areas.			X	X
5. The CLPPP will continue to provide training as needed on preventing lead poisoning to prenatal and child health				X

coordinators, MCH Home Visiting agencies and HCCNH child care health consultants.				
6. The CLPPP will continue to promote screening by providing materials for the Medicaid enrollment packets.			X	
7. The CLPPP will continue surveillance on testing of refugee children and alert providers when refugee children are overdue for testing.				X
8. The CLPPP will continue to cross-match Medicaid enrollment records with the lead test database to identify screening status.				X
9. The CLPPP will use the Healthy Homes Statewide Strategic Plan and Healthy Homes Steering Committee to develop activities and program evaluation measures to increase stakeholder involvement and to improve the health of NH families and their homes.				X
10. The CLPPP will continue to plan with the Department of Information Technology (DoIT) to implement the CDC HHLPSS, a new data management system, in the winter of 2010.				X

b. Current Activities

SURVEILLANCE AND DATA ANALYSIS:
The CLPPP continues to cross-match Medicaid enrollment records to identify screening status. (IB)

The CLPPP epidemiologist continues surveillance of refugee children and alerts providers when refugee children are overdue for testing. (IB)

QUALITY ASSURANCE AND TECHNICAL ASSISTANCE:
The CLPPP is collaborating with Dartmouth Hitchcock Medical Center to hold an educational session for health care professionals on screening and management of blood lead levels in children. (PB, IB)

The CLPPP completed revisions to the Screening and Management Guidelines in December 2009. (IB)

The CLPPP continues to contact health care providers to advise confirmatory testing within recommended timeframes in the Screening Guidelines. (IB)

The CLPPP continues to attend MCH Coordinators' Meetings to share information updates with Title V funded Child Health and Primary Care. (IB)

MCH continues to monitor the lead screening activities of the primary care grantees, and Child Health Services. (IB)

The CLPPP continues to provide training as needed on preventing lead poisoning to prenatal and child health coordinators, MCH Home Visiting agencies and HCCNH child care health consultants. (IB)

The CLPPP continues to promote screening by offering materials to be included in Medicaid enrollment packets. (PB)

The CLPPP continues to facilitate and provide technical assistance to Local Lead Action and Healthy Homes Committees in highest risk areas. (IB, PB)

c. Plan for the Coming Year

Although this measure is being discontinued due to the findings of the Title V needs assessment process, the CLPPP will continue to promote and educate the testing of Medicaid eligible children for lead.

State Performance Measure 4: *Percent of third grade children screened who had untreated dental decay.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	24.2	22	24	24.2	22
Annual Indicator	24.2	24.2	24.2	24.2	14.7
Numerator	142	142	142	142	443
Denominator	587	587	587	587	3015
Data Source				3rd grade survey	3rd Grade Survey
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	22	22	22	22	

Notes - 2009
Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The data for 2009 is new.

Please note: statewide prevalence estimates are weighted to represent NH third grade students, and to account for selection probability and non-response. Using the weighting, the result for this measure is 12%, not 14.7.

Notes - 2008
Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The next data from the survey will not be available until the fall of 2009.

Notes - 2007
Statewide oral health data for NPM #9 and SPM #4 is generally collected every five years through the Oral Health Survey of Third Grade Children. The next data from the survey will not be available until the spring of 2010.

a. Last Year's Accomplishments
DATA ANALYSIS:
The OHP collaborated with the Chronic Disease Epidemiologist and developed a scientific manuscript that was published as an abstract in the Journal of Public Health Dentistry on the oral health results of the 2008 Head Start Healthy Smiles-Healthy Growth Survey. The abstract reported on the prevalence of ECC, untreated decay, history of decay, and treatment urgency among enrolled children ages 3-5 years in 27 randomly selected Head Start sites to demonstrate the need for early intervention. (IB, ES, PBS, DS).

The Oral Health Program (OHP) collaborated with the DPHS Chronic Disease Epidemiologist and the Obesity prevention Program (formerly the Nutrition and Health Promotion Program) to collect and analyze data (including untreated decay) from 3,051 third grade students enrolled in 81 randomly selected schools for NH's Healthy Smiles-Healthy Growth Third Grade Survey. (IBS, PBS, ES, DS)

SYSTEMS BUILDING:

The OHP worked with the Medicaid Dental Director to increase the number of enrolled dental providers and improve access to oral health care for underserved, at-risk children. (IB, ES, PBS, DS)

The OHP collaborated with the Medicaid Dental Director, the NH Dental Society, the Concord Sealant Coalition and other communities to promote the evidence-based effectiveness of school sealant programs that link children identified with untreated decay to a "dental home." (IB, PBS, ES, DS).

The OHP collaborated with the DPHS Diabetes Program to inform and educate medical and dental professionals and diabetes stakeholders about the impact of oral health on diabetes disease management. (IBS, PBS, ES).

The OHP collaborated with key stakeholders to support the June 9, 2009 opening of a new dental center to provide access to oral health care for children and adults living in Sullivan County with the lowest dentist to patient ration in NH. (IBS, PBS, ES, DS)

The OHP collaborated with the DPHS Chronic Disease Epidemiologist to develop a scientific abstract for publication in the Journal of Public Health Dentistry on the oral health results of the 2008 Head Start Healthy Smiles-Healthy Growth Survey describing the prevalence of ECC, untreated decay, history of decay, and treatment urgency among enrolled children to demonstrate the need for early intervention. (IB, ES, PBS, DS).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collect, analyze and report on data from the Healthy Smiles-Healthy Growth Third Grade Survey that provided the first regional data on the body mass index and oral health status, including untreated decay, among NH's children.				X
2. Partner with the Head Start State Collaborative Office and the NH Pediatric Dental Society to launch and implement the American Academy of Pediatric Dentists' Head Start Dental Home Initiative.				X
3. Collaborate with the Women, Infants and Children (WIC) Program to improve access to preventive and restorative oral health care for enrolled children at higher risk for ECC, untreated decay, and history of decay, especially for WIC families that li	X	X		X
4. Collaborate with the DPHS Diabetes Program to educate medical and dental professionals about the impact of oral health on diabetes disease management and link diabetes patients to oral health care.			X	X
5. Collaborate with the Medicaid Dental Director, the NH Dental Society, the Concord Sealant Coalition and 11 state funded school sealant programs to promote the evidence-based effectiveness of school sealant programs that also link children identifie				X
6. Collaborate with the Chronic Disease Epidemiologist to annually collect and analyze oral health data and provide programmatic feedback on the presence of untreated decay among NH's 3rd graders.				X
7. Complete and distribute the strategic oral health workforce				X

plan that will affect the supply, diversity, cultural competence, composition and distribution of NH's oral health workforce				
8.				
9.				
10.				

b. Current Activities

DATA ANALYSIS:
The OHP is collaborating with Dr. Sherry Buerrer, CDC EIS Officer, the DPHS Chronic Disease Epidemiologist and the Obesity Prevention Program to analyze and report on data (including untreated decay) collected on 3,051 3rd grade students in 81 randomly selected NH schools that will provide the first county level survey results on the oral health and BMI status of NH children.

SYSTEMS BUILDING:
The OHP's work is ongoing with the Medicaid Dental Director to inform and educate the dental professional community with the goal of increasing the number of enrolled dental providers and improving access to preventive and restorative oral health care for NH's underserved residents. (IB, ES, PBS, DS)

The OHP is collaborating with the Medicaid Dental Director, the NH Dental Society, the Concord Sealant Coalition and key stakeholders in Hillsborough to promote the evidence-based effectiveness of school sealant programs that also link children identified with untreated decay to restorative care in a "dental home." (IB, PBS, ES, DS)

The OHP is collaborating with the State Head Start Collaborative Office to improve access to preventive and restorative oral health care for children enrolled in Head Start and at greater risk for ECC, untreated decay, history of decay, and urgent treatment, especially those who live in the Tri-County region and in Nashua. (IB, ES, PBS, DS).

c. Plan for the Coming Year

Even though this measure is being discontinued due to the findings of the Title V needs assessment process, the Title V and the Oral Health Program will continue to monitor untreated decay.

DATA ANALYSIS:
The OHP will continue working with the Chronic Disease Epidemiologist to annually collect and analyze oral health data and provide programmatic feedback on the presence of untreated decay among NH's third grade students enrolled in 21 school-based oral health programs in 181 (59%) of NH's elementary schools. (IBS, PBS, ES.)

The OHP will work with CDC and the Chronic Disease Epidemiologist to publish a scientific manuscript, "Emergency Department Visits for Non-Traumatic Dental Conditions, New Hampshire, 2001-2008" to document the impact to the health care delivery system of dental visits to NH hospital emergency departments. (IBS, PBS, ES).

SYSTEMS BUILDING:
The OHP will work with the Medicaid Dental Director to inform and educate the dental professional community with the goal of increasing the number of enrolled dental providers and improving access to preventive and restorative oral health care. (IB, ES, PBS, DS)

The OHP will collaborate with the Medicaid Dental Director, the NH Dental Society, the Concord Sealant Coalition and key stakeholders in Hillsborough to promote the evidence-based

effectiveness of school oral health programs that also link identified children with restorative care and a "dental home." (IB, PBS, ES, DS).

The OHP will collaborate with the Medicaid program, Easter Seals and the Endowment for Health to sustain newly opened dental centers in Manchester and Sullivan County. (IB, PBS, ES, DS)

The OHP will collaborate with the DPHS Diabetes Program to inform and educate diabetes stakeholders about the impact of oral health on diabetes disease management. (IBS, PBS, ES).

The OHP will collaborate with NH Head Start and WIC programs to improve access to preventive and restorative oral health care for enrolled children at higher risk for ECC, untreated decay, history of decay, and urgent treatment to demonstrate the need for early intervention. (IB, ES, PBS, DS).

The OHP will publish and distribute a strategic oral health workforce plan that will affect the supply, diversity, cultural competence, composition and distribution of NH's oral health workforce, especially those professionals who treat very young children and residents of rural, underserved NH communities. (IBS, PBS, ES).

State Performance Measure 5: *The rate (per 100,000) of emergency department visits among youths aged 15-19 resulting from being an occupant in a motor vehicle crash*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	2500	2300	2300	2200	2100
Annual Indicator	2,207.6	1,807.3	1,609.9	1,276.4	1,952.7
Numerator	2114	1753	1581	1269	1894
Denominator	95761	96995	98207	99421	96995
Data Source				Vital Records	Vital Records
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2000	1900	1800	1700	

Notes - 2009
2009 data is not available, and 2007 and 2008 data is provisional. Therefore, the *final* data from 2006 is used.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2008
2007 and 2008 data is missing NH residents who received treatment out of state.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2007
2007 and 2008 data is missing NH residents who received treatment out of state.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

a. Last Year's Accomplishments
a. Last Year's Accomplishments
The MCH Injury Prevention Program continued to lead efforts to decrease the number and rate of deaths to children aged 14 years and younger caused by motor vehicle crashes. In collaboration with many partners, positive outcomes have been accomplished through participation in strategic planning; outreach and education; and policy development. (IB, PB)

Teen Driving Committee (TDC):
The Injury Prevention Program Manager continued to chair the TDC, which met on a monthly basis. The TDC utilized the New Hampshire Strategic Highway Safety Plan as its action plan. (IB)

As part of the action plan, the development phase for a website for parents of novice drivers was entered into by the TDC and the Brain Injury Association of New Hampshire. This website will be housed on the Department of Safety's website. (IB)

A consultant was hired (with outside funds) to facilitate telephone surveys with parents of novice teen drivers. The TDC designed the survey, which was undertaken with 18 parents of novice drivers who live across the state. When asked what they most would like to see on a web site, the majority of respondents answered the rules and regulations of driving in the state. This fits in nicely with the site being hosted by the Department of Safety. Some comments included, "Preparing for scenarios…like what to do if a deer jumps out in front of you. How many hours to spend in the car with them" and "Rules not only for New Hampshire, but for surrounding states; because often when we're practicing highway driving we are driving to another state. Also the situations kids will be put into, and how to discuss these with your kids." However, only half of the respondents had actually been to any website for information on teen driving. Most said they received information from things given to them by drivers' education instructors. Interestingly, those same parents said they would have liked to have known about a website for their number one source of information because it was easier. Additional information on methods used to get the word out about the website as well as suggested parental methods to make a better teen driver were also gathered. (IB)

The TDC worked with legislators this past year on a bill strengthening the state's graduated drivers' licensing system (GDL) for novice drivers. The bill was voted down in the House. However, the TDC has continued to explore ways to work with law enforcement, driver education instructors, parents, and adolescents to increase awareness of the current graduated drivers' licensing system. (IB)

Last year, the TDC was approached by the University of North Carolina's Center for the Study of Young Drivers, Highway Safety Research Center. The CDC had funded them to help states understand the latest in GDL research and strategize initiatives designed to help tighten policy and laws. They were interested in working with the TDC on graduated drivers licensing in New Hampshire, which was reciprocated. (IB)

Traffic Safety Conference:
A traffic safety conference was held in April of 2009. It included a track on adolescent driving. The traffic safety conference was organized by a statewide collaboration of organizations, including

the Injury Prevention Program.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop parent website on novice driving.			X	X
2. Develop and facilitate strategic policy session regarding Graduated Drivers Licensing in collaboration with University of North Carolina.				X
3. Monitor progress of graduated drivers' licensing legislation.				X
4. Facilitate monthly meetings of the Teen Driving Committee.				X
5. Revise teen driving section of Strategic Highway Safety Plan.				X
6. Secure identified funding for ongoing planning and implementation of motor vehicle crash prevention activities.				X
7. Work to help increase enforcement of the seat belt law for teenagers through training and best practice measures			X	X
8.				
9.				
10.				

b. Current Activities

Using the state's Strategic Highway Safety Plan the MCH Injury Prevention Program will continue to enhance current partnerships and develop new relationships to implement evidence-based education and policy development. (PB)

Teen Driving Committee (TDC):
The TDC, in collaboration with colleagues from the University of North Carolina, held a symposium on graduated drivers licensing (gdl) in October of 2009. Approximately forty people attended. The symposium focused on data and research behind the use of gdl. Plans are being made to host a strategic policy symposium in June with the same partners. (IB)

Development of the parent website is continuing based on survey results. (PB)

The TDC is currently updating the teen driving section of New Hampshire's Strategic Highway Safety Plan spearheaded by the Department of Transportation. This serves as the TDC work plan for the upcoming year. The Injury Prevention Program Manager will continue to encourage the use of additional data including emergency department visits and emergency medical services' runs as a result of motor vehicle crashes to aid in strategic planning. (IB)

In collaboration with the Highway Safety Agency, the TDC plans on increasing enforcement of the primary seat belt law (up through age 17) through various training and best practice measures (PB, IB).

c. Plan for the Coming Year

Even though this exact measure is being discontinued due to the findings of the Title V needs assessment process, MCH will continue to monitor emergency department visits as a result of motor vehicle crashes in this age group and implement appropriate strategies and interventions.

Teen Driving Committee (TDC):
The TDC will finish the website specific to New Hampshire's graduated drivers' licensing system

for parents. The website will be coordinated and supported in-kind with the help of the New Hampshire Department of Transportation and the New Hampshire Department of Safety. A marketing campaign to go along with the website will be developed, dependent upon funding. This campaign will include hard copy and electronic parent guides as well as media messages. (PB)

The TDC will facilitate with the help of the University of North Carolina's Center for the Study of Young Drivers, Highway Safety Research Center a large- scale parent phone survey. This will determine a baseline for attitudes and knowledge with respect to graduated drivers' licensing in New Hampshire. The survey will assess parental attitudes towards the different pieces of a model GDL system (permitting phase, restricted passengers and night driving, etc.). It will also determine parents' knowledge of the current GDL system in New Hampshire. The survey results will be collected and analyzed in a report. (IB, PB)

The TDC will also host a strategic policy development session with the University of North Carolina's Center for Young Drivers, Highway Safety Research Center. It is hoped that colleagues will forward any policy work discussed in the 2010-2011 legislative session.

The TDC will facilitate the implementation of the activities identified in the funded Department of Transportation proposal. Those include activities already discussed as well as a larger media campaign focused on parents.

State Performance Measure 6: *Percent of adolescents (ages 10-20) eligible for an EPSDT service who received an EPSDT service during the past year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	35	40	42	45	46
Annual Indicator	41.5	41.4	43.5	45.2	53.2
Numerator	12127	12976	13739	14495	18459
Denominator	29205	31352	31579	32069	34729
Data Source				416 EPSDT report	416 EPDST report
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	47	48	49	50	

Notes - 2009
From FY2009 416 report via Maria Pliakos (ext 7194) and Jackie Leone.

Notes - 2008
From FY2008 416 report via Maria Pliakos (ext 7194) and Jackie Leone.

Notes - 2007
From FY2007 416 report via Maria Pliakos (ext 7194) and Jackie Leone.

a. Last Year's Accomplishments
The Adolescent Health Program revisited the strategic plan implementation and moved current activities into action statewide through stakeholder meetings.
(IB)

The Adolescent Health Program continued to work with external resource partners and built

stronger collaboration with other state programs, particularly in New England. The Adolescent Health Coordinator facilitated a monthly regional call to exchange information. (IB)

The Adolescent Health Program contracted with one agency, Child Health Services in Manchester, to provide adolescent-focused clinical preventive services. (DHC) The program provided adolescent-specific oversight to all of the MCH-funded primary care agencies, and continued to provide technical assistance to ensure evidence-based practice. (IB)

In collaboration with MCH quality assurance, site visits and performance measures assessed the adequacy of adolescent health preventive services by MCH funded agencies. Last year a new performance indicator was added essentially mimicking the MCH performance measure, but not specifically for Medicaid eligible adolescents. This new performance measure looks at the percentage of adolescent annual well-child checks over the denominator of total amount of adolescent patients. Several primary care sites participated in a trial run of the indicator with it going "live" for State Fiscal Year 10. (IB)

The Adolescent Health Program continued its work with the Department of Education to develop and implement the Coordinated School Health Plan. The Coordinated School Health Council had interns from the University of New Hampshire working on the strategic plan, and trained more school districts on the CDC School Health Index. (IB)

The Adolescent Health Program continued to update social networking sites to provide preventive health information and resources to adolescents where it was easily accessible for the population. (PB)

The Adolescent Health Program Coordinator resigned effective Fall 2009. (IB)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH will continue to provide adolescent clinical contract, oversight, and technical assistance.				X
2. MCH will continue to provide primary care contract adolescent-specific technical assistance.				X
3. MCH will perform chart audits and review annual exams during site-visits and performance measure work plans of MCH-funded agencies				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Adolescent Health Program is working with the LEAH (Leadership Education in Adolescent Health) and the Konopka Institute for Best Practices in Adolescent Health to provide resources and information to MCH funded agencies, other youth serving organizations and community partners in New Hampshire. The Adolescent Health program is building stronger collaborations with other state programs targeting youth providing regular and updated information and resources. (IB)

MCH continues to provide adolescent-specific oversight to the MCH-funded primary care agencies, and technical assistance to ensure evidence-based practice as well as provides additional funds to Child Health Services in Manchester to provide adolescent-focused clinical preventive services. (DHC)

MCH developed a new clinical adolescent health performance indicator for all primary care centers that focuses on increasing the number of adolescents receiving annual health maintenance visits. The denominator for this measure is the total amount of current adolescent patients. Several centers have different definitions for "current patient" which makes any comparison amongst centers difficult. The Adolescent Health Program is working to determine if there is a similar national measure or if the current indicator can be redefined. (IB)

c. Plan for the Coming Year
This State Perfomance Measure is being discontinued.

However, future Annual Reports proposals will include information on the status of adolescent health care including, but not limited to, performance measures, site visits, and the MCH quality assurance program. The Adolescent Health Program will also continue to review MCH funded agencies' patient reminder systems and electronic medical record system documentation to make recommendations about updating systems to increase visits and screenings. (IB)

State Performance Measure 7: *Percent of center-based child care facilities in the MCH catchment area and serving children under age 2, that are visited at least once a month by a child care health consultant*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		5	5	4	16
Annual Indicator		0.0	1.8	14.3	
Numerator		0	1	5	
Denominator		43	55	35	
Data Source				Survey	
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	25	35	40	

Notes - 2009
This data has been collected in the past through a survey. Due to funding issues and decreased personnel, we were unable to do the survey for 2009.

Notes - 2008
This year's catchment area was more limited in size than the previous year, thus the decrease in the number of facilities surveyed. Despite this decrease, the number of on-site visits to child care facilities by a child care health consultant increased .

Notes - 2007
Although most centers did not have a monthly on-site visit by a child care health consultant, many child care centers did have at least one on-site visit in the year 2007.

Number of centers surveyed: 55

Number of on-site visits by a child care health consultant to centers: 67

Number of children in attendance at the centers on an average day: 813

The survey was conducted by telephone. In addition to the collection of more accurate data by phone, this had the advantage of personalized marketing of the child care health consultation network. Follow-up thank you letters will be sent to the providers, with specific health and safety information that they requested during the survey; they will also be sent contact information for their child health care health consultant.

a. Last Year's Accomplishments
HCCNH led the formation of the health and safety subcommittee of NH Child Care Advisory Council. Mission and initial responsibilities of committee were established. (PB)

HCCNH participated in meetings with the public advocacy organization, ELNH. Primary focus of HCCNH input has been to advocate for the incorporation of health and safety measures into the evolving Quality Rating Improvement System (PB)

HCCNH provided administrative oversight and assistance to Easter Seals New Hampshire, the child care health consultation contractor who provided consultation services and health and safety trainings for child care providers through 6/30/09. HCCNH provided trainings and technical support to child care health consultants by telephone, email and on site at child care facilities. (IB)

HCCNH contributed to the revision of the national health and safety performance standards for out of home child care programs, Caring for Our Children. (IB)

HCCNH contributed to the revision of the New Hampshire child care licensing standards resulting in the addition of the following requirements:
· Medication administration training for all licensed child care providers and
· Child care environment free of conditions hazardous to children including ensuring safe conditions associated with the use and storage of pesticides. (IB)

HCCNH collaborated with Nutrition and Health Promotion Section and Department of Agriculture to secure federal funds for child care initiatives for Integrated Pest Management (IPM). (IB)

NH Association of Infant Mental Health, made up of early childhood stakeholders, conducted "Mental Health Services for NH's Young Children and their Families: Planning to Improve Access and Outcomes". (IB)

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue participation in the Health and Safety subcommittee of the New Hampshire Child Care Advisory Committee.				X
2. Continue to provide trainings and technical support to child care health consultants by telephone, email and on site at child care facilities.				X
3. Continue to improve and sustain access to child care health consultation in early care and learning programs.				X
4. Continue to expand opportunities for continued education for child care providers and teachers.				X
5. Continue collaborative efforts with Region 1 Healthy Child Care America.				X

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Funding reductions from the federal ECCS grant resulted in the inability to provide child care health consultant contract at the beginning of fiscal year 2010. (ES)

HCCNH continues to look at strategic ways to sustain statewide system of child care health consultation. (IB)

National Infant & Toddler Child Care Initiative, "Supporting Consultants Working with Early Care and Education Settings Serving Infants and Toddlers" began in NH in the fall of 2009. (PB)

As part of the state team, HCCNH participated in the I Am Moving, I Am Learning (IMIL) training and is preparing for IMIL to be introduced at the Child and Adult Care Food Program's (CACFP) conference in May 2009. (ES)

The Health and Safety subcommittee of NH Child Care Advisory Council designed a universal health care form for children attending child care programs. (IB)

HCCNH provides technical assistance to specialists in the Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC) project who consult to child care providers in the HEAL (Healthy Eating, Active Living) Public Health network regions. (PB)

Healthy Child Care New England web-portal created for training and technical assistance. (IB)

Due to funding reductions QRIS (Quality Rating and Improvement System) work has been delayed.

Over 225 child care providers attended trainings and workshops provided through HCCNH. (ES)

c. Plan for the Coming Year
Although this measure is being discontinued due to the findings of the Title V needs assessment process, the Title V will incorporate this work into the efforts of the New Hampshire early Childhood Advisory Council and the New Hampshire Early Childhood Systems Project. (ECCS).

HCCNH will improve and sustain access to child care health consultation in early care and learning programs through the following activities:
· HCCNH will provide recommendations that child care health consultants be incorporated into NH's QRIS. (IB)
· Implementing "Supporting Consultants Working with Early Care and Education Settings Serving Infants and Toddlers" (IB)
i. HCCNH will help create, disseminate, and analyze the results of a statewide survey of child care providers who use consultants in their programs to help determine the baseline for community based child care health consultation. (IB)
ii. A stakeholder group of public and private partners will be convened to develop consultation training across early childhood systems that align with the early childhood professional development system in NH.

HCCNH will expand opportunities for continued education for child care providers and teachers through the following activities:

· HCCNH and DCYF-CDB will recommend, choose, and adapt medication administration modules for web-accessibility for NH's child care provider community and promote a face-to-face component for assessment purposes. (ES)

HCCNH will increase the quality of child care in NH through the following activities:
· The NH Child Care Facilities Integrated Pest Management (IPM) Initiative will conduct a two-year survey of NH child care providers on present practices of integrated pest management for child care facilities. (IB)
· The Health and Safety committee's Universal Health Form will be reviewed, edited and accepted by the NH Pediatric Society and the NH Child Care Licensing Unit. It will then be rolled out in Head Start, Child Care, and WIC programs. (IB)
· The Health and Safety committee will also work with healthcare providers to include this form as an electronic document, as well as work with NH DOE to disseminate the form to special education preschool programs. (IB)
· As part of the state planning team, HCCNH will work toward the integration of IMIL into the child care community. (IB)

State Performance Measure 9: *[REVISED]:The percent of CSHCN who are at risk for/are overweight or obese*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	25	8	8
Annual Indicator					
Numerator		14	13	25	14
Denominator		164	143	243	243
Data Source				SMS clinic reports	SMS clinic reports
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8	8	8	8	

Notes - 2009
This reflects those children with a BMI of 96% or greater. If the population of children with a BMI of 85-95% (identified by the CDC as "at risk for overweight") is included, the percentage more than doubles from 6.17% to 16.30%. The numbers represent solely a select population of children who are being served by the Neuromotor Clinic Program.

Notes - 2008
This reflects those children with a BMI of 95% or greater. If the population of children with a BMI of 85-95% (identified by the CDC as "at risk for overweight") is included, the percentage more than doubles from 10.29% to 17.70%. The numbers represent solely a select population of children who are being served by the Neuromotor Clinic Program.

a. Last Year's Accomplishments
The BMI data collection process for the outcome-based measure was expected to include a larger population, in this reporting year. SMS staff (Cahill) had reviewed this measure with the clinical coordinator of Dartmouth-Hitchcock Medical Center Spina Bifida clinic. The data was not obtained from DHMC due to their staffing limitations, therefore the data this year continues to capture the population of participants in SMS' neuromotor clinics.

The physical activity component of the HIPFit program was continued (see attachment) and was

formalized as a program run by one of SMS' physical therapy contractors. Twelve children with disabilities who were at risk of obesity continued to participate in a twice a week exercise program of aerobic and weight training.

SMS staff (Butler) continued to participate in the NH Healthy Schools Coalition, and in other statewide efforts to develop an obesity plan. She also participated in activities of the National Action for Healthy Kids initiative.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Attempted to recruit for participants in multidisciplinary program design to include: nursing, physical therapy, and nutrition for children with mobiliity impairment, who are at risk for/are overweight or obese.		X		X
2. Continued to use data collection tool (BMI, Ht. & wt, age of child) and review process used across SMS neuromotor clinic populations		X		X
3. SMS participation in the NH affiliate of the National Action for Healthy Kids				X
4. SMS representation at the national meeting of the National Action for Healthy Kids				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SMS continues to utilize the BMI data collection tool to capture the populations of participants in the neuromotor clinics. This data continues to be significant in relation to trends in the CSHCN population that attribute a higher rate of overweight/obesity than in non-CSHCN (2007 NSCH).

The clinical providers of the original HIPFit program have been asked to review individual components in order to identify aspects that might be able to be shared with other groups/providers. The goal of this effort will be to attempt to facilitate the spread of tools/techniques that might be beneficial to CSHCN, who are not candidates due to their lack of proximity to the facilities utilized.

SMS staff (Butler) continued to participate in the NH Healthy Schools Coalition in other statewide efforts to help to represent the unique needs of CSHCN.

c. Plan for the Coming Year

Though this performance measure will be discontinued in the next fiscal year SMS will continue with its efforts to meet the needs of the population of CSHCN, who are at risk for or are overweight. SMS has started the planning process for a Fall 2010 workshop on the need to incorporate CSHCN in statewide activities addressing overweight and obesity. This will be presented in conjunction with experts from Boston University through the Knowledge to Practice Technical Assistance for Region I. The Neuromotor clinics will also continue to collect and review

BMI data. In addition the SMS data system will have the ability to record this information for all enrollees.

State Performance Measure 10: *[REVISED]: The percent of respite/childcare providers, serving medically and behaviorally complex children, who have participated in competence-based training.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		0	20	20	50
Annual Indicator					
Numerator		0	0	7	17
Denominator		1	1	9	124
Data Source				College of Direct Support training records	College of Direct Support training records
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	

Notes - 2009
In response to ongoing development of this measure the detail sheet has been edited to more accurately reflect the goal. For reporting purposes the numbers identified reflect the total number of providers from Crotched Mountain Rehabilitation Center and the Moore Center who have participated in the recommended training (College of Direct Support) and what percentage work with medically and behaviorally complex children.

Notes - 2008
In response to ongoing development of this measure the detail sheet has been edited to more accurately reflect the goal. For reporting purposes the numbers identified reflect the total number of providers from Crotched Mountain Rehabilitation Center who have participated in the recommended training (College of Direct Support) and what percentage work with medically and behaviorally complex children.

a. Last Year's Accomplishments
An inventory and review of training outlines, via web search, with the identification of the core elements critical to a basic respite curriculum was completed by August 2008. The plan included identifying the core competencies necessary to provide quality respite/childcare services to CSHCN; identifying the training mechanisms that will meet the wide diversity of provider workforce needs and sharing the information with identified partners. The advisory group identified the core elements and competencies necessary to address each core element and is reflective of diverse geographic, cultural and disability concerns and identified potential qualified training partners and their constituents. Integration of core elements and competencies into a curriculum in a series of modules was identified and found that the on-line curriculum available through the College of Direct Support met the identified criteria. This web based competency program has been available in NH. This curriculum has an evaluation tool incorporated into the 40- hour training and a certificate is provided upon completion. Data has been collected as to those currently trained utilizing this program. Documentation from one agency shows that turnover in support staff after training has been reduced from 50% to 20% since incorporating this training and in 2008-2009 it dropped to 12% turnover.

The Lifespan Respite opportunity came out May 2009; a stakeholder group was pulled together. In collaboration with Bureau of Elderly and Adult Services, Bureau of Developmental Disabilities, Bureau of Behavioral Health, Division of Children and Youth, National Alliance on Mental Illness NH, NH Family Voices, and the College of Direct Support, SMS agreed to submit and wrote the application for Lifespan Respite Care Project for July 2009 submission date. These stakeholders agreed that New Hampshire (NH) has no statewide coordinated system of accessible, community-based respite care services for family caregivers of elders, children and adults with mental illness and others who have significant behavioral or medical support needs. The system is weak because there is no established workforce; there is no pool of providers because there is not a system of formalized training and recruitment. The application goal: to increase availability of trained Lifespan Respite Care (LRC) providers for New Hampshire residents. The objectives are: 1) choose direct support training modules appropriate to respite care providers, modifying them to meet the project needs 2) develop training modules for the Severely Emotionally Disturbed (SED) and the Traumatic Brain Injured (TBI) population 3) develop a marketing campaign to recruit and train providers 4) design and implement a coordinated registry providing access to fully trained respite care providers 5) institute a pilot for the LRC targeting a specific population with SED based upon the model of NH DCYF Adoptive Care Respite Pilot 6) have the work plan and evaluation for sustainability of LRC be overseen by the Planning Advisory Group.

Outcomes of Lifespan Respite Care project include: 1) developed, expanded and marketed comprehensive respite training curriculum to meet the Lifespan Respite Care needs of NH residents; 2) established and coordinated registry of trained LRC providers 3) a completed pilot utilizing the LRC trained providers, targeting children and youth with Severe Emotional Disturbance Planning continues to involve an investigation of mechanisms to maintain sustainability and to tie funding for respite services to quality training.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand the Advisory Planning Group for Respite/Childcare to meet the needs identified for NH Lifespan Respite Care.				X
2. Consensus from expanded group that the curriculum and training meets the needs for providers of respite through the lifespan.				X
3. Continue coordination of Advisory Planning Group for Lifespan Respite collaboration representing families, state agencies and private not-for-profits to identify sustainability measures.				X
4. Meeting with individuals and groups in state agencies and communities regarding respite/childcare needs for medically and behaviorally complex children and fostering collaboration among the individuals and groups.				X
5. Participating in State and local activities that are associated with respite/childcare to help build collaboration and infrastructure.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SMS submitted and received the Federal Lifespan Respite Grant (coordinated state system for respite services to include training) in September 2009. The expansion of the Advisory Planning

Group (Title V staff, parent consultant, State Behavioral Health (BBH) staff, Parent/Director Council for Children and Adolescents with Chronic Health Conditions (CCACHC), State Bureau of Developmental Service (BDS) staff and a partner, knowledgeable in medically fragile children from the private sector) to include the State Bureau of Elderly and Adult (BEAS), the Division of Children and Youth (DCYF), National Alliance Mental Illness New Hampshire (NAMINH), Granite States Federation for Children Mental Health (GSFFCMH), parents of a foster child and NH local community based agency for competency based training. These members of the Advisory Planning Group divided into work groups (Curriculum, Locator, Pilot, Marketing, and Coalition). These workgroups are charged with meeting the schedule of the Lifespan Respite Care Work Plan. The Advisory Planning Group has been meeting monthly via "Go To Meetings" where updated are given from each of the workgroups.

c. Plan for the Coming Year

While the focus for SMS/Title V initiatives for respite is on CSHCN and competency-based training for respite/childcare providers for this population, surveys continue to show a need for respite services in New Hampshire throughout all ages of life. BEAS and BDS shared survey and focus group materials with the coalition workgroup. In June 2009 Service Coordinators who currently serve families with CSHCN below three years of age to identify these families respite care needs. The limited responses show there is a high need for trained competency-based respite providers for children under three years of age. Reimbursement for respite providers for children below three years of age is currently unavailable. The Child Care Bureau has incurred major cuts to their budget that has impacted greatly the local child care incomes and parents ability to pay the increased costs of multiple children in their families. Early Head Start Programs in NH has increase by three this year to now a total of 6 in the state. There is a need for competency-based trained providers for childcare and head start to care for CSHCN.

The Coalition work group has developed the vision/mission for the NHLRC and now The Advisory Planning group will take on the responsibility for the NH Lifespan Respite Coalition (a mandate of the grant). The Lifespan Respite Provider (LRP) College of Direct Support (CDS) competency based curriculum has been designed with a 3 tier implementation, the first tier is mandatory before providing any respite care (approximately 20-24 hours). The pilot will be under surveillance by SMS and the Advisory Planning Group for the next two years to identify any changes necessary to meet the needs of the respite providers, the caregivers and their families. This will be through pre-post surveys in the Pilot programs. The Pilot programs have been identified as adoptive families or reunified families from the DCYF system who have a child with serious emotional disturbance. The major LRC Providers to be trained will be identified by the families or natural supports and with assistance from the DCYF local offices. The training will be free for the respite providers The LRC Providers will be reimbursed by the grant for the pilots for up to 50 hours per family at $10.00 per hour.

The NH Provider Respite Locator will be designed by SMS. This locator (a system for access initially by State Agencies to assist families in need of respite) will identify the respite providers who have successfully completed the training and who wish to be on the Locator. The marketing work group will have a logo adopted for recognition of the NHLRC program. This work group will begin to identify other marketing material for the NHLRC program. SMS will continue to collaborate with agencies and groups in the State to identify respite/childcare needs and help build infrastructure to meet the respite needs of individuals throughout the lifespan.

E. Health Status Indicators

Introduction

Overall, the Health Status Indicators serve as useful tools in assessment, monitoring, and evaluating programmatic activities. The following narrative describes trends in New Hampshire

followed by a broader assessment of NH's capacity to utilize these and other Title V indicators to direct public health efforts.

The NH Title V program is limited in fully utilizing these health status indicators to direct public health efforts, provide surveillance and monitoring, and to evaluate the effectiveness of programs. The primary limitation is the scope to which Title V can affect population-based indicators. Through our partnerships with community health centers, community based organizations and other state agencies, however, Title V provides assistance and leadership in developing promising practices and strategies to address the needs that these indicate illustrate. The limitation occurs in the amount of resources Title V can provide to support these efforts.

In the past, Title V has also encountered infrastructure challenges in accessing and using the most current data that MCHB requests as health status indicators.The NH Division of Vital Records (VR) moved from the Department of Health and Human Services to the Department of State in 2003. A change in leadership at VR occurred in 2009 and has resulted in an improved working relationship. A memorandum of understanding addressing, among other issues, the timeliness of data entry was finalized and signed in 2009.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.3	6.4	5.8	6.5	6.5
Numerator	800	817	736	890	890
Denominator	12780	12788	12688	13665	13665
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is unavailable. Data from 2008 is used as an estimate.

Notes - 2007
Data does not include out-of-state births (unavailable).

Narrative:
Low birth weight (LBW) is a strong predictor of infant health and survival. LBW babies may face serious health and development complications such as respiratory disorders, intestinal complications and developmental delays. Infants born below 5.5 pounds (2,500 grams) are low birth weight.

In 2009, 6.5%, or 890 New Hampshire infants, were born with low birth weight. Although this data has shown slight variation, it has not significantly changed in the past few years and continues to compare favorably with the rest of the United States, it does not negate the emotional, medical, and economic costs of LBW babies. This data creates a powerful incentive to address prevention efforts throughout NH communities.

The Prenatal Data Linkage Project was formed to link MCH-funded prenatal clinic records and NH birth data to assure MCH is able to fully understand and respond to the needs of, and threats

to, pregnant women and newborns. Additionally, this project will greatly assist in program management, policy development, and evaluation of health services to pregnant women and newborns. This data from this linkage will be used in comparison with the indicators listed above to more accurately describe the health of the vulnerable populations that receive care in MCH funded health agencies. The PCDF is now operational; data on all clients entering care at MCH-funded prenatal clinics on or after July 1, 2007 has been entered into the system. MCH is currently analyzing the data and has shared preliminary reports with the MCH-funded prenatal clinics.

Because smoking during pregnancy may account for 20 to 30% of low birthweight babes and in New Hampshire 16% of women report smoking during pregnancy, the Title V program has elevated tobacco use among pregnant women and women of reproductive age as one of strategic priorities. Specifically, MCH agencies will work in partnership with DPHS Tobacco Prevention and Control Program to strengthen cessation programs through innovative learning collaboratives in MCH-funded community health centers. This is of critical importance since 43% of women who received prenatal care in these centers reported smoking 3 months prior to becoming pregnant.

Low birthweight, prematurity, and other related data to inform the newly formed Infant Mortality Review Panel and Maternal Mortality Review Panel that were just signed into law in June 2010.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	4.5	4.3	4.6	4.5	4.5
Numerator	558	528	558	585	585
Denominator	12314	12257	12262	13099	13099
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is unavailable. Data from 2008 is used as an estimate.

Notes - 2007
Does not include out-of-state births (unavailable for 2007).

Narrative:
Low birth weight (LBW) is a strong predictor of infant health and survival. LBW babies may face serious health and development complications such as respiratory disorders, intestinal complications and developmental delays. Infants born below 5.5 pounds (2,500 grams) are low birth weight. There are two main reasons why an infant may be born with low birth weight.

Premature birth: Babies born before 37 completed weeks of pregnancy are called premature.

About 67 percent of low-birthweight babies are premature. Some premature babies born near term do not have low birthweight, and they may have only mild or no health problems as newborns.

Fetal growth restriction: These babies are called growth-restricted, small-for-gestational age or small-for-date. These babies may be full term, but they are underweight. Some of these babies are healthy, even though they are small. They may be small simply because their parents are smaller than average. Others have low birthweight because something slowed or halted their growth in the uterus.

Preterm birth has enormous health, social and economic costs. It increases the risks of infant mortality and of serious health consequences throughout the lifespan. Preterm birth rates have been slowly climbing nationally and in NH, but the data suggests that there may be possibly a trend towards a decrease beginning in 2007. Disparities are evident among racial, ethnic and socio-economic groups. Interventions such as maternal smoking cessation have the potential to reduce premature births, and thus reduce the impact of low birthweight, and are well within the scope of Title V activities.

As stated in Health Status Indicator 1A, smoking is an important determinant of health and a significant factor contributing to preterm and low birthweight births. Data and activities related to smoking cessation efforts are described within that section.

In 2006, about 1 in 14 babies (7.4% of live births) was late preterm in New Hampshire. The rise in late preterm births has been linked to rising rates of early induction of labor and c-sections. The MCH Epidemiologist has continued an extensive analysis of NH birth hospital data to examine apparent elective c-section rates in "late" preterm. This information will be shared with hospitals and providers to guide practice.

Low birthweight, prematurity, and other related data to inform the newly formed Infant Mortality Review Panel and Maternal Mortality Review Panel that were just signed into law in June 2010.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.1	1.0	0.9	0.8	1.1
Numerator	136	129	118	104	145
Denominator	12780	12767	12673	12369	13665
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Out-of-state births not included (unavailable for 2009).

Notes - 2008
Out-of-state births not included (unavailable for 2008).

Notes - 2007

Out-of-state births not included (unavailable for 2007).

Narrative:
In 2009, approximately 1%, or 145 New Hampshire infants, were born weighing less than 1,500 grams. Although this data has not significantly changed in the past few years and continues to compare favorably with the rest of the United States, it does not negate the emotional, medical, and economic costs of low birth weight and very low birth weight babies. This data creates a powerful incentive to address prevention efforts throughout NH communities.

Among populations that Title V has a more direct relationship with through the support of community health centers (CHCs) with prenatal programs, several factors may be present that put women at risk for negative birth outcomes, inlcuding very low birthweight. Innovative strategies like Text4Baby, are being explored to engage women early in their pregnancy.

To assist Quality Assurance efforts at the CHCs, the web-based Perinatal Client Data Form (PCDF) linkage system contains 2007 and 2008 data. Comparison data from the PCDF was presented at the Spring 2010 MCH Directors' meeting. Agencies were given numbers privately identifying their own agency while comparisons on different performance measures were shown onscreen. This type of activity is intended to increase awareness of the quality of prenatal care for some of the most vulnerable pregnant women in the state.

This Health Status Indicator, however, also includes the prevalence of low birthweight babies that may be from populations that are do not generally receive care in community health centers, including high risk women with with multiple births. Since the 1980s, multiple births have increased substantially in the United States. The increase in multiple births has been attributed to an increased use of Artificial Reproductive Technology and delayed childbearing. In 2006, in New Hampshire, there were 236 deliveries as a result of ART with 304 infants born. Forty-four percent were born in multiple birth deliveries; 41% in twin deliveries and 2% in higher order deliveries. Nationally, 6.3% of all ART infants were born with very low birthweight. Almost two percent (1.9%) of singletons were VLBW, 8.5% of twins were VBLW and 34.3% of triplets or higher order multiples were VLBW. (MMWR, June 12, 2009)

In order to best understand this entire population of vulnerable infants, increased surveillance is needed. The linkage between birth datasets, maternal discharges and birth certificates (by social security numbers), was recently approved and received for analysis. The MCH Epidemiologist will utilize these linked datasets to address birth outcome disparities among hospital service areas. Analyses that are being worked on include, but are not limited to induction of labor, elective cesarean section, and maternal mortality.

The MCH Epidemiologist is part of the Northern New England Perinatal Quality Indicators Network (NEPQIN), based at Dartmouth Hitchcock Medical Center. They are attempting to obtain AHRQ status.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0.7	0.6	0.7	0.7	0.7
Numerator	88	71	86	87	87
Denominator	12314	12257	12262	13099	13099
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data is unavailable. Data from 2008 is used as an estimate.

Notes - 2007
Out-of-state births not included (unavailable for 2007).

Narrative:
In 2009, approximately 1%, or 145 New Hampshire infants, were born weighing less than 1,500 grams. Although this data has not significantly changed in the past few years and continues to compare favorably with the rest of the United States, it does not negate the emotional, medical, and economic costs of low birth weight and very low birth weight babies. This data creates a powerful incentive to address prevention efforts throughout NH communities.

Among populations that Title V has a more direct relationship with through the support of community health centers (CHCs) with prenatal programs, several factors may be present that put women at risk for negative birth outcomes, inlcuding very low birthweight. Innovative strategies like Text4Baby, are being explored to engage women early in their pregnancy.

To assist Quality Assurance efforts at the CHCs, the web-based Perinatal Client Data Form (PCDF) linkage system contains 2007 and 2008 data. Comparison data from the PCDF was presented at the Spring 2010 MCH Directors' meeting. Agencies were given numbers privately identifying their own agency while comparisons on different performance measures were shown onscreen. This type of activity is intended to increase awareness of the quality of prenatal care for some of the most vulnerable pregnant women in the state.

This Health Status Indicator, however, also includes the prevalence of low birthweight babies that may be from populations that are do not generally receive care in community health centers, including high risk women with with multiple births. Since the 1980s, multiple births have increased substantially in the United States. The increase in multiple births has been attributed to an increased use of Artificial Reproductive Technology and delayed childbearing. In 2006, in New Hampshire, there were 236 deliveries as a result of ART with 304 infants born. Forty-four percent were born in multiple birth deliveries; 41% in twin deliveries and 2% in higher order deliveries. Nationally, 6.3% of all ART infants were born with very low birthweight. Almost two percent (1.9%) of singletons were VLBW, 8.5% of twins were VBLW and 34.3% of triplets or higher order multiples were VLBW. (MMWR, June 12, 2009)

In order to best understand this entire population of vulnerable infants, increased surveillance is needed. The linkage between birth datasets, maternal discharges and birth certificates (by social security numbers), was recently approved and received for analysis. The MCH Epidemiologist will utilize these linked datasets to address birth outcome disparities among hospital service areas. Analyses that are being worked on include, but are not limited to induction of labor, elective cesarean section, and maternal mortality.

The MCH Epidemiologist is also part of the Northern New England Perinatal Quality Indicators Network (NEPQIN), based at Dartmouth Hitchcock Medical Center. They are attempting to obtain AHRQ status.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.3	3.3	4.1	5.4	5.4
Numerator	8	8	10	13	13
Denominator	245896	243822	241716	239613	239613
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is unavailable, so 2008 data is used.

2008 data is provisional due to incompleteness of data from out-of-state.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2008
2008 data is provisional due to incompleteness of data from out-of-state.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2007
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Narrative:
Unintentional injuries are the leading cause of death for children in New Hampshire aged one and older. However, because there are so few deaths, the data needs to be utilized cautiously and statistical analysis can be difficult since differences may be due to chance alone. One death can increase the rate significantly.

Among children 1 to 4, drowning continued to be the leading mechanism of death. For age 5 to 14, the mechanism switches to motor vehicle crashes. Both of these are consistent with national data.

The New Hampshire Injury Prevention Program (IPP) is located within the Maternal and Child Health Section. It aims to reduce morbidity and mortality due to intentional and unintentional injuries by focusing its efforts on those high incidence injuries that are most amenable to public health interventions. The IPP contracts with the Injury Prevention Center at Dartmouth to facilitate Safe Kids New Hampshire, the main coalition in the state addressing unintentional injuries in children.

Employees of MCH, including the Child Health Nurse Consultant and the Injury Prevention Program Manager, are members of the New Hampshire Child Fatality Review Committee. The committee, which meets monthly, includes a review of pediatric deaths from unintentional injuries. The committee's biannual report, released October 2009 summarizing the work of the committee in 2007 and 2008, contained information on the recommendations, and their follow up, for three cases of unintentional injury deaths that had been reviewed. The recommendations spanned the disciplines represented on the committee. Since Fall 2009, MCH has coordinated with the Office of the Medical Examiner to in sending grief packets to non-SUID/non-suicide pediatric deaths. These packets include information and referral sources.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	0	0	1	1	1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August, 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Notes - 2008
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August, 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Notes - 2007
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

At the annual federal review in August, 2009, it was decided that it would be more appropriate for NH to use the small numbers box than to use the Standard Ratio Methodology as outlined in the Block Grant guidance. Note: the small numbers box is used when "there are fewer than 5 events and when the average number of events over the last 3 years is fewer than 5, and therefore a 3-year moving average cannot be applied".

Narrative:
Data associated with motor vehicle deaths is collected from various data sources including, but not limited to, vital records, hospitals, emergency responders, and police reports (Fatal Accident Reporting System). A new electronic system, funded by the New Hampshire Highway Safety Agency, is being put into place for police crash reports, both for fatal and non-fatal injuries. This will help ensure that fields are filled out and timely data is gathered. The reporting for emergency responders, TEMSIS, is now being collected from the majority of departments in the state. Because of this, the data for motor vehicle crashes is more detailed than others.

One cause of concern specific to this age group is the appropriate use of child passenger seats and safety restraints within motor vehicles. The Injury Prevention Center is the site of the New Hampshire Child Passenger Safety Program with 1.0FTE funded by the New Hampshire Highway Safety Agency. This position coordinates all of the certified child passenger safety technicians in the state as well as the fitting/inspection stations.

During the last year, fifteen car seat check events (large events with instructors present, usually held at car dealerships or another public location) were held. At these events, 286 seats were checked or newly installed. It is interesting to note that 77% of those seats checked required modification in order to be installed correctly. There were 1756 seats checked by the fitting/inspection stations for a total of 2090 seats checked for the year.

Two National Highway Traffic Safety Administration child passenger safety seat technician trainings were held. Approximately 40 technicians graduated and were certified. The Injury Prevention Program Manager recertified as a child passenger safety technician. This is a process that takes place every two years and requires taking an electronic test, completing a certain number of continuing education credits, participating in at least two community events, and getting five different car seat installations checked off by a senior instructor.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance	2005	2006	2007	2008	2009

Data					
Annual Indicator	6.0	8.0	6.8	10.2	10.2
Numerator	11	15	13	20	20
Denominator	183353	187372	191336	195306	195306
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is unavailable; 2008 provisional data is used as an estimate.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2008
2008 data is provisional due to the incompleteness of out-of-state data.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2007
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Narrative:
The rate of unintentional injury deaths increases by approximately 300% between the ages of 14 and 16 . Thus, adolescents are more likely to die by unintentional injuries than are younger children (even though unintentional injuries are still the leading cause of death for children one and above).

The Injury Prevention Program co-facilitates the New Hampshire Teen Driving Committee (TDC) which was formed after a 2006 roundtable symposium on the issue hosted by the CDC and the State and Territorial Injury Prevention Directors' Association (now Safe States Alliance). The TDC wrote the adolescent component of the 2007 New Hampshire Strategic Highway Safety Plan and is now updating the plan for 2011. The TDC uses the plan as an outline for its own action plan including goals, objectives, and activities. Strategies in the Strategic Highway Safety Plan include increased enforcement of existing seat belt laws, increased community engagement in enforcement and education on adolescent seat belt use, strengthening the graduated drivers' licensing law and adding advanced skill training to drivers' education. The members of the TDC, both as individual agencies and as a whole, have been at the forefront of all of these.

The plan was also used as a basis for a proposal to the Department of Transportation for funding of activities. This proposal was just accepted and is in the process of being written for Governor and Council approval. One of the planned activities is a website for parents of novice drivers. This website will be housed on the Department of Safety's website. The development phase of the project has already started.

A consultant was hired (with outside funds) to facilitate telephone surveys to parents of novice teen drivers. The TDC designed the survey, which was undertaken with 18 parents who live across the state. When asked what they most would like to see on a web site, the majority of respondents answered the rules and regulations of driving in the state. This fits in nicely with the site being hosted by the Department of Safety. Some comments included, "Preparing for scenarios…like what to do if a deer jumps out in front of you. How many hours to spend in the car with them" and "Rules not only for New Hampshire, but for surrounding states; because often when we're practicing highway driving we are driving to another state. Also the situations kids will be put into, and how to discuss these with your kids." However, only half of the respondents had actually been to any website for information on teen driving. Most said they received information from things given to them by drivers' education instructors. Interestingly, those same parents said they would have liked to have known about a website for their number one source of information because it was easier. Additional information on methods used to get the word out about the website as well as suggested parental methods to make a better teen driver were also gathered.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	113.1	127.6	128.7	129.8	129.8
Numerator	278	311	311	311	311
Denominator	245896	243822	241716	239613	239613
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 data is unavailable. 2008 is used as an estimate.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2008
2007 and 2008 data is incomplete for NH residents who received treatment out of state.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2007
2007 and 2008 data is incomplete for NH residents who received treatment out of state.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Narrative:
Nationally, falls are the leading cause of unintentional injuries among children 0 to 19. They're also responsible for approximately one-quarter of all childhood unintentional injury costs. In New Hampshire, falls are also the leading cause of unintentional injury emergency department visits and hospitalizations for ages 0 to 24. The falls rate in New Hampshire was approximately 1,000 hospitalizations/100,000 for ages 0 to 17 (2000-2004) and approximately 12,000 emergency department visits/100,000 for ages 0 to 17 (2000-2004).

Nonfatal fall rates nationally are highest amongst children ages one to four. In New Hampshire, rates for hospitalizations due to falls (2001-2005) were highest in 15 to 17 year olds among the focus age groups. Rates for emergency department visits (2001-2005) were highest in the zero to four and 10 to 14 age groups.

Emergency department visits due to falls from furniture (beds and chairs were the most common) were a significant issue for children 0 to four years of age in New Hampshire, but gave way to slips and trips and falls with sports equipment from age five on (2000-2006). Within the category of sports equipment, falls from playground equipment occurred the most. Fractures and contusions were the result of most fall related emergency deparment visits during the same time period (2000-2006).

Injurious falls in children are due to many things including, but not limited to, lack of access to and inadequate protective equipment, inexperience, lack of supervision, parental awareness, layout of family home, and social norms that don't promote safety.

Safe Kids New Hampshire, a coalition of diverse professionals dedicated to reducing unintentional injuries is children, is facilitated by the Injury Prevention Center at Dartmouth, a contractor of the Injury Prevention Program within MCH. Meeting quarterly, members participate in professional development sessions as well as
plan interventions. Falls in children is a priority.

Information on low cost helmet and safety equipment is sent to all public schools and recreation departments in the state as well as posted online. Additional best practices are continuing to be explored.

An annual Safe Kids 500 is held at the Loudon Speedway (a NASCAR race site) every year. The intent is for parents and children to ride appropriately helmeted on their bikes around on the racetrack. In May 2010, over 600 parents and children attended with close to 100 helmets both fitted and distributed.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.9	6.6	5.8	2.5	5.8
Numerator	17	16	14	6	14
Denominator	245896	243822	241716	239613	241716
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2007 is the most recent year for which complete data is available. Therefore, this has been used as an estimate for 2009 (there is no provisional data for 2009).

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2008
2008 data does not include NH residents who received treatment out of state.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2007
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Narrative:
Many of the nonfatal injuries due to motor vehicle crashes among children could have been prevented or diminished through the use of proper child passenger restraints. As was previously stated, the Injury Prevention Center is the site of the New Hampshire Child Passenger Safety Program (NH CPSP). This past year, CPSP facilitated a technician update for all registered car seat technicians in the state. As part of the recertification process, technicians must take at least 6 hours of professional training. This update qualified for that. The first part of the day focused on the physics of crashes and reducing injuries to young children through new vehicle and car seat technology. This included discussion of rebound management, energy absorption, belt paths, LATCH connectors, lock-offs, and harness adjustment systems. The second part of the day

centered on hands on practice installing seats into motor vehicles. It is hoped that this training will be repeated for 2011.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	93.3	91.3	73.2	36.4	73.2
Numerator	171	171	140	71	140
Denominator	183353	187372	191336	195306	191336
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2009 provisional data is not available. Therefore, 2007 complete data is used as an estimate.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2008
2008 data does not include NH residents who received treatment out of state.

Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Notes - 2007
Starting with the year 2005, NH is using the following document as guidance for injury data:

Johnson RL, Thomas KE, Sarmiento K. State Injury Indicators: Instructions for Preparing 2005 Data. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.

Narrative:
Adolescents have the highest incidence and rate of motor vehicle related death and injury. Although adolescents hold only 7% of the driver licenses in the state of New Hampshire, their death rate is substantially higher than any other age group. The risk of motor vehicle crashes is higher among 16- to 19-year-olds than among any other age group. In fact, per mile driven,

adolescent drivers ages 16 to 19 are four times more likely than older drivers to crash . In NH, adolescents accounted for 6.5 percent of the population and 17 percent of the total amount of motor vehicle crashes.

It is interesting to note that adolescents had a higher inpatient discharge rate for injuries due to motor vehicle traffic crashes for adolescents 15 to 17, but lower emergency department visit rate for injuries due to motor vehicle crashes for adolescents 15 to 17, within a five-year period (2001-2005). Adolescents 15-24 have a higher rate of hospitalizations for motor vehicle crashes than any other age group (within this focus age group). In general, emergency medical responders attended to more cases of New Hampshire16-year-olds due to motor vehicle crashes, than any other adolescent age group (2007, 2008, and 2009 data). Males were more likely to be hospitalized, while females were more likely to be seen in the emergency department and discharged (2001-2005).

Most of the crashes occurred on local roads, where speed, inexperience, and drug use were contributing factors. Adolescent drivers, just starting out, have several risk factors working against them. First, is their inexperience behind the steering wheel. The second is their greater likelihood of engaging in risky driving behaviors such as speeding, driving under the influence, and following other vehicles too closely. New adolescent drivers tend to overestimate their own driving abilities and underestimate the dangers on the road. In 2001-2009, speed was the number one cause of fatal crashes involving 16 and 17 year olds and the majority happened between 9 p.m. and midnight.

A proven way of reducing the risk for an unintentional injury is to wear a seatbelt while riding in a motor vehicle. In the 2009 Youth Risk Behavior Survey, 12.9% of the students who participated answered yes to "Never or rarely wore a seatbelt when riding in a car driven by someone else". This has steadily decreased since 1993 when 27.6% answered yes to the question. However, the trend is both linear and quadratic which means that although decreasing, it is now leveling off. This can be construed as a cause for worry and suggests there is work to be done. According to the 2009 New Hampshire Highway Safety Agency belt observation study, adolescent drivers have decreased belt usage from 51.6% in 2006 to 47.6% in 2009. Although decreased, these figures have remained relatively stable since 2006, which is also of concern. Male and female adolescent drivers differ with males buckling up 41.7% and females 55.6% in 2009.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	11.2	11.7	12.0	12.0	10.6
Numerator	528	550	562	563	499
Denominator	46969	46955	46955	46955	46955
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Numerator is from Heather Barto (3932) and Dana Hull, Communicable Disease Surveillance Section.

Denominator is from the US Bureau of the Census, Estimates Branch.

Notes - 2008
Numerator is from Heather Barto (3932) and Dana Hull, Communicable Disease Surveillance Section.

Denominator is from the US Bureau of the Census, Estimates Branch.

Notes - 2007
Numerator is from Heather Barto, Communicable Disease Surveillance Section, 271-3932.

Denominator is from the US Bureau of the Census, Estimates Branch.

Narrative:

Chlamydia (CT) incidence continues to have an increasing presence in NH with as it has for the last several years. The NH STD Prevention Program and Title X Family Planning Program (FPP) continue to associate the increase in cases to the continuation of screening and enhanced surveillance both in the private provider settings and publicly funded sites.

In 2009, there were a total of 499 CT cases amongst 15-19 year olds females (32% of the female cases). CT continues to be a female dominated infection with 73% female cases. Screening of males at Family Planning clinics is limited to partners of women who test positive for the edisease and/or are symptomatice for CT. These individuals are tested and/or treated in accordance wit hthe CDC STD treatment guidelines. Males who are at lower risk for CT are referred to the STD/HIV Clinics and/or other private providers for screening.

Due to women under the age of 25 (inclusive of adolescents) being at high risk for chlamydia, the FPP and STD programs prioritize this age group for follow-up education, assurance that treatment was completed, encourage follow-up testing per CDC guidelines, and provide partner notification. FPP currently contracts with 12 agencies (26 clinical sites). These contracted agencies will target the following related objectives in there workplans:
1. Screening of all women <25 for CT
2. Treatment of women with a positive CT within 14-30 days of speciman collection
3. Re-screening of women diagnosed with chlamydia 3-4 months after the completion of their treatment

These efforts are further supported through the FPP partnership with the STD program and the DPHS Lab as we oversee NH's involvement with the Infertility Prevention Project (IPP). Currently one juvenile detention center and fourteen eligible Family Planning Clinics (clinic sites with a minimum 3% positivity rate) participate in the IPP. These clinic sites target:
1. All women <25 annually
2. Women >25 who are symptomatic or have had new or multiple partners since their last tested
3. Partners of women who have had a positive test; and any client who had a postive CT within the past 3-4 months and has not been re-tested.

The STD Program and the FPP take several steps to assure that all publicly funded programs are adhering to CDC STD Treatment Guidelines and accordingly supporting practices that will ultimately reduce infection carriage. They are investigating the proportion of positive cases who either don't get timely treatment (within 30 days of diagnosis) or who are not retested within 3-4 months of a positive test result. With this information, they are identifying barriers to implementing these recommended treatment standards and training sites on ways to overcome

them.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.5	3.3	4.4	4.6	4.7
Numerator	788	736	953	1008	1025
Denominator	222334	220289	217692	217692	217692
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator is from Heather Barto (3932) and Dana Hull, Communicable Disease Surveillance Section.

Denominator is from the US Bureau of the Census, Estimates Branch.

Notes - 2008
Numerator is from Heather Barto (3932) and Dana Hull, Communicable Disease Surveillance Section.

Denominator is from the US Bureau of the Census, Estimates Branch.

Notes - 2007
Numerator is from Heather Barto (3932) and Dana Hull, Communicable Disease Surveillance Section.

Denominator is from the US Bureau of the Census, Estimates Branch.

Narrative:
Chlamydia (CT), incidence has continued to have an increasing presence in NH, as it has for the last several years. The NH STD Prevention Program and Title X Family Planning Program (FPP) continue to associate the increase in cases to the continuation of screening and enhanced surveillance both in the private provider settings and publicly funded sites.

CT continues to be a female dominated infection with 73% female cases. The age group most largely affected by chlamydia is the 20-24 year olds females where there were 684 cases in 2009 (44% of all the famale cases and 67% of the cases within the 20-44 age group). Screening of males at Family Planning clinics is limited to partners of women who test positive for the edisease and/or are symptomatice for CT. These individuals are tested and/or treated in accordance wit hthe CDC STD treatment guidelines. Males who are at lower risk for CT are referred to the STD/HIV Clinics and/or other private providers for screening.

Due to women under the age of 25 (inclusive of adolescents) being at high risk for chlamydia, the FPP and STD programs prioritize this age group for follow-up education, assurance that

treatment was completed, encourage follow-up testing per CDC guidelines, and provide partner notification. FPP currently contracts with 12 agencies (26 clinical sites). These contracted agencies will target the following related objectives in there workplans:

4. Screening of all women <25 for CT
5. Treatment of women with a positive CT within 14-30 days of speciman collection
6. Re-screening of women diagnosed with chlamydia 3-4 months after the completion of their treatment

These efforts are further supported through the FPP partnership with the STD program and the DPHS Lab as we oversee NH's involvement with the Infertility Prevention Project (IPP). Currently one juvenile detention center and fourteen eligible Family Planning Clinics (clinic sites with a minimum 3% positivity rate) participate in the IPP. These clinic sites target:

4. All women <25 annually
5. Women >25 who are symptomatic or have had new or multiple partners since their last tested
6. Partners of women who have had a positive test; and any client who had a postive CT within the past 3-4 months and has not been re-tested.

The STD Program and the FPP take several steps to assure that all publicly funded programs are adhering to CDC STD Treatment Guidelines and accordingly supporting practices that will ultimately reduce infection carriage. They are investigating the proportion of positive cases who either don't get timely treatment (within 30 days of diagnosis) or who are not retested within 3-4 months of a positive test result. With this information, they are identifying barriers to implementing these recommended treatment standards and training sites on ways to overcome them.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	14260	13162	286	48	395	6	363	0
Children 1 through 4	60865	55820	1527	155	1856	30	1477	0
Children 5 through 9	78400	72477	1913	218	2009	28	1755	0
Children 10 through 14	87081	82191	1495	219	1560	37	1579	0
Children 15 through 19	93691	89561	1325	290	1343	40	1132	0
Children 20 through 24	82705	78622	1079	340	1493	39	1132	0
Children 0 through 24	417002	391833	7625	1270	8656	180	7438	0

Notes - 2011

Narrative:

To better understand this Health Status Indicator, it is important to recognize that New Hampshire's population is aging. Over 25% of the population is 55 years of age or older. The 55-74 year old segment of the population will be proportionally larger in New Hampshire than the rest of the nation in 2010. New Hampshire is now tied with Florida with the fourth highest median age in the nation and the third highest in the New England region at 40.2 years.

Children and adolescents (ages 0 to 24 years) represent over 30 % of New Hampshire's total population. The overall population of New Hampshire children is declining; New Hampshire Office of Energy and Planning population projections suggest that the cohort of children ages 5-19 will continue to decline over the next 15 years.

However, where there is growth in the state, especially in the southern tier, there is growing diversity and as might be expected based on the differing racial and ethnic proportions in younger age groups, births in New Hampshire are also becoming more ethnically and racially diverse. The percentage of births to racial and ethnic minority groups has more than doubled over the past decade. In 2008 and in 2009, over 17 percent of resident births were to parents where at least one reported a race/ethnicity other than non-Hispanic white, compared to only 7.6 percent of births in 1998.

Almost half of all the minorities in the state live in the Manchester-Nashua urban area in the southern tier of the state. According to a University of New Hampshire, Carsey Institute Report on the Changing Demographics of Manchester and Nashua, minority population growth and migration accounted for almost all the growth in these communities from 2000-2007. This area is the most racially diverse in the state, with nearly 11% of the total population belonging to a minority group.

In 2008, natural population growth throughout New Hampshire remained constant, but it was noted that domestic residents were relocating out of New Hampshire at a slightly higher rate than international newcomers settled within the state, causing a very small downward shift in the overall migration rate and population.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	13728	532	0
Children 1 through 4	58621	2244	0
Children 5 through 9	75433	2967	0
Children 10 through 14	84271	2810	0
Children 15 through 19	91137	2554	0
Children 20 through 24	80333	2372	0
Children 0 through 24	403523	13479	0

Notes - 2011

Narrative:
Three percent of New Hampshire's children and young adults are of Hispanic ethnicity. Hispanic children are generally proportionately represented across all age groups. As with racial minorities, approximately half of the ethnic minorities in New Hampshire live in the urban areas of

Manchester and Nashua in Hillsborough County. Providers in these communities are growing their capacity to provide quality services that are culturally competent and linguistically relevant.

Please see HSI # 6A for more information on this indicator.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	4	4	0	0	0	0	0	0
Women 15 through 17	212	186	0	0	0	0	8	18
Women 18 through 19	691	620	12	1	0	1	9	48
Women 20 through 34	10427	9348	151	10	380	7	80	451
Women 35 or older	2350	2100	41	7	96	2	26	78
Women of all ages	13684	12258	204	18	476	10	123	595

Notes - 2011

Narrative:
This Health Status Indicator allows Title V to analyze the maternal population in another way to better understand the demographics of our state and potential risk factors.

Although New Hampshire has grown faster than other states in New England this decade, it has experienced a leveling off in the past two years. New Hampshire and other New England states are losing population share to faster-growing states in other regions of the country. Much of this movement has to do with a decline in economic opportunities at home coupled with economic growth in other states.

The second reason is demographically driven and not specific to New Hampshire. Young people tend to be the most mobile, and with fewer ties to their communities such as school-aged children or home ownership, they tend to "leave the nest" and spend time in other states. Only time will tell if the recently publicized credit crunch and decline in the housing market will serve to keep young people more rooted. (New Hampshire Economic Analysis Report 2008)

Particular to this Health Status Indicator, the fertility rate in New Hampshire has remained steady even as the national rate has been increasing in the last few years. Comparitively, New Hampshire has the nation's lowest fertility rate: forty-two babies are born per 1000 women of childbearing age, compared to the national average of 54.9 babies. (NH Office of Energy and Planning, 2009) The most populous counties (Hillsborough and Rockingham) show the largest decreases in the number of births in recent years.

New Hampshire is fortunate to have one of the lowest teen birth rates in the country. In 2009, there were a total of 217 births to women age 17 and under, and among those births 186 were to

white mothers; 18 were to women for whom race was not recorded or was unknown; 8 to women of more than one race ; and zero births to Black/African American women, American Indian, Asian, or Native Hawaiian in this age cohort.

The largest population having children are women age 20-34. Although, New Hampshire has a significant number women of advanced maternal age. This can lead to complications such as increased risk for prematurity and low birthweight.

These data once again also describe a state that is predominantly White, with a small minority population. While the state's population is still 93.1% white (non-Hispanic), minority populations are increasing. The State's largest racial minority is Asian, representing 1.9% of the total population, followed by Black/African American at 1.2%. Hispanics (of all races) make up 2.6 % of the total population.

However, the age groups have disproportionate numbers of racial and ethnic minorities. Younger age groups are increasingly diverse. The percentage of births to racial and ethnic minorities has doubled over the past decade. In 2008 and 2009, over 17% of resident births were to parents where at least one parent reported a race or ethnicity other than non-Hispanic white, compared to 7.6% in 1998.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	4	0	0
Women 15 through 17	178	24	10
Women 18 through 19	601	51	39
Women 20 through 34	8991	404	1032
Women 35 or older	1956	63	331
Women of all ages	11730	542	1412

Notes - 2011

Narrative:
Approximately 4% of New Hampshire's mothers are of Hispanic ethnicity. The data suggests that women of Hispanic ethnicity are not proportionately represented across all age groups. They tend to be more represented in younger age cohorts, including ages 15-17. This data should be interpreted carefully, however, due to the relatively large number of women for whom ethnicity is not reported.

As with racial minorities, approximately half of the ethnic minorities in New Hampshire live in the urban areas of Manchester and Nashua in Hillsborough County. Providers in these communities are growing their capacity to provide quality services that are culturally competent and linguistically relevant.

Please see HSI # 6A for more information on this indicator.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	80	73	4	1	0	1	1	0
Children 1 through 4	12	11	0	0	0	0	1	0
Children 5 through 9	10	10	0	0	0	0	0	0
Children 10 through 14	13	11	1	0	1	0	0	0
Children 15 through 19	41	40	0	0	0	0	0	1
Children 20 through 24	69	68	1	0	0	0	0	0
Children 0 through 24	225	213	6	1	1	1	2	1

Notes - 2011

Narrative:
New Hampshire is in the fortunate position of having few child deaths. The Child Fatality Review, in which MCH participates, is able to investigate deaths that appear troublesome or from which state systems can learn lessons and develop strategies to prevent further injury or death. There are so few child deaths in the state annually (168 deaths in children age 0-24 in 2007) that any analyses on the data require the use of multi-year trends, especially in regard to differences among ethnic or racial groups.

MCH continues to dedicate significant staff resources to better educate health care and social service providers about deaths in infancy caused by unsafe sleep conditions. The MCH SIDS Program Coordinator provides many in-services to a variety of health and child care personnel on reducing the risk of SIDS, and on promoting safe sleeping to decrease deaths from accidental overlay or asphyxiation, including working with hospitals on bed sharing policies.

To help us better understand other causes of infant death, the New Hampshire Legislature passed SB410 in June 2010 establishing a committee to study New Hampshire's rate of infant mortality. The committee will be comprised of legislators and will be charged with developing proposals for remediation

Deaths among children older than one are often attributable to injury. Populations that require attention include adolescents aged 15-19 years and young adults aged 20-24 years. Motor vehicle deaths are common in these data sets. New Hampshire mirrors national trends of unintentional injury and specifically Motor Vehicle related injuries being the leading cause of death among adolescents in these age groups. However, poisonings are increasing as the second leading cause, especially with unintentional poisonings with prescription drugs. This data is the basis for promoting activities aimed at improving seat belt usage among adolescents.

Suicide is another unfortunate factor in these age groups. Attempted suicides in high school

students in the 2005 New Hampshire YRBS were reported by 10.8% of female students and 2.8% of male students. Title V has focused increased attention to suicide prevention activities in partnership with mental health agencies and community-based partners.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	79	1	3
Children 1 through 4	11	1	0
Children 5 through 9	10	0	0
Children 10 through 14	13	0	0
Children 15 through 19	41	0	0
Children 20 through 24	68	1	1
Children 0 through 24	222	3	4

Notes - 2011

Narrative:
New Hampshire is in the fortunate position of having few child deaths. The Child Fatality Review, in which MCH participates, is able to investigate deaths that appear troublesome or from which state systems can learn lessons and develop strategies to prevent further injury or death. There are so few child deaths in the state annually (168 deaths in children age 0-24 in 2007) that any analyses on the data require the use of multi-year trends, especially in regard to differences among ethnic or racial groups.

The limit of 20 deaths is a convenient, if somewhat arbitrary, benchmark, below which rates are considered to be too statistically unreliable for presentation or analysis. With only two known Hispanic or Latino child deaths, age 0-24, in 2007, and four deaths where ethnicity was not reported, New Hampshire has yet to do the sort of multi year analysis needed to better understand if these ethnic groups are disproportionately effected.

Please see comments for Health Status Indicator #08A for additional information.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**

All children 0 through 19	334516	313211	6546	930	7163	141	6525	0	2007
Percent in household headed by single parent	20.0	19.5	40.0	32.0	11.2	29.5	29.3	35.0	2006
Percent in TANF (Grant) families	2.9	2.9	8.0	2.1	1.9	5.7	0.0	0.0	2009
Number enrolled in Medicaid	94607	89474	3252	92	1000	69	0	720	2009
Number enrolled in SCHIP	83021	80021	2200	100	600	100	0	0	2009
Number living in foster home care	893	788	64	9	3	4	25	0	2009
Number enrolled in food stamp program	44658	42115	2075	45	384	32	0	7	2009
Number enrolled in WIC	20079	17906	826	169	398	398	382	0	2009
Rate (per 100,000) of juvenile crime arrests	1450.0	1450.0	1450.0	1450.0	1450.0	1450.0	1450.0	1450.0	2009
Percentage of high school drop-outs (grade 9 through 12)	1.7	1.7	1.7	1.7	1.7	1.7	1.7	1.7	2009

Notes - 2011
Race numbers are estimated.

Race and ethnicity data for juvenile arrests is unavailable or unreliable.

Race information is not available.

Narrative:
These data are complex and tell many stories. By looking at the numbers of children in certain programs such as WIC and Food Stamps, it is apparent that poverty is affecting the lives of NH residents; the percentage of children receiving food stamps and number of families receiving TANF is at its highest point in a decade. It is critical that Title V continue to work with all social service safety net programs component and coordinate efforts as we support community health centers and other programs such as home visiting. Title V programs understand that with limited resources, health care providers must leverage all possible supports for the families that they serve. It is important to understand the racial disparities in poverty and access to services, but some services still do not track race and ethnicity, possibly due NH's historically small minority population.

Across all populations, TANF, Food Stamps, and Medicaid has seen exponential growth in the past two years. In 2010, there was a 10.1% year over year increase in the number of Medicaid

enrollees. Rates have been reduced to providers and controls have been proposed on multiple services.

Similar trends have been seen in TANF. Caseloads have exceeded projections in the State Budget causing deficits. Year to date in SFY10, there has been a 21% increase in TANF recipients. At this rate, the budget can expect a $2.4 Million shortfall for cash assistance for families due to increased need.

As need has grown, MCH and WIC have worked together to better integrate services through enhanced outreach and enrollment for WIC at MCH-agencies. MCH has collaborated more with state-level WIC staff to facilitate WIC enrollment for clients from the MCH-contract agencies. State agency staff have convened to share best practices with local agencies, developing a form to prevent duplication of health screening, etc, and promoted joint projects like Text4Baby.

These data also point to interesting trends in eduction. The good news is that most of NH's students graduate from high school at a rate consistently higher than the national average. On average, 78% of high school freshmen graduate with a high school diploma, 5% more than the national average. But work must be done to engage youth that do not have a positive relationship with schools or other traditional mentors. A recent survey of the free time choices of youth in rural Coos County showed that out of school experiences have the potential for either contributing to or limiting positive development. Results confirmed the intuitive notion that youth who were most involved in activities during their out-of-school time reported higher grades, a more positive attitude towards school, a stronger sense of belonging at school, and more positive expectations for the future than both their moderately and less involved peers. (http://www.carseyinstitute.unh.edu/publications/IB_Sharp_Out_of_School.pdf, accessed 6/10/10)

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	323409	11107	0	2007
Percent in household headed by single parent	19.6	33.0	0.0	2006
Percent in TANF (Grant) families	2.7	6.5	0.0	2009
Number enrolled in Medicaid	88226	5661	720	2009
Number enrolled in SCHIP	0	0	83021	2009
Number living in foster home care	818	75	0	2009
Number enrolled in food stamp program	41699	3328	0	2009
Number enrolled in WIC	0	0	20079	2009
Rate (per 100,000) of juvenile crime arrests	1450.0	1450.0	1450.0	2009
Percentage of high school drop-outs (grade 9 through 12)	1.7	1.7	1.7	2009

Notes - 2011
Race information not available.

Narrative:

Although New Hampshire's population is still predominately non-hispanic, white, our youngest residents our becoming increasingly diverse.

Nationally, children of foreign-born parents are more likely to be low income than children of native-born parents. For example, even in New Hampshire, where the overall numbers are small, Hispanic or Latino families are over-represented in the TANF population. Additionally, Hispanic or Latino populations are also over-represented among households headed by a single parent creating additional opportunities for economic vulnerability.

Racial and ethnic minorities in New Hampshire are more likely to live in poverty than New Hampshire's white population. The differences between the percentage of white, non-Hispanic residents living below 100% of FPL (7.3%) and Black/African American (21.9%) "some other race" (14.5%) and Hispanic (of any race) (13.6%) residents is statistically significant. The percantage of foreign-born New Hampshire residents with incomes below 100% of poverty is 9% versus 7% of native born New Hampshire residents.

It should also be noted that ethnicity is not collected for Rate (per 100,000) of juvenile crime arrests or percentage of high school drop-outs (grade 9 through 12).

Nearly 50% of all minority residents of the state reside in the Manchester-Nashua urban corridor of Hillsborough County. Hispanics, the largest minority, number just over 19,000 individuals. This minority population has also fueled the population growth in these communities. They tend to be younger, and unfortunately, they also tend to have lower incomes and to disproportionately in need of social services than their neighbors.
(http://www.carseyinstitute.unh.edu/publications/IB-Johnson-Manchester.pdf accessed 6/10/10)

See HSI # 9A for more information on this indicator.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	202207
Living in rural areas	132309
Living in frontier areas	0
Total - all children 0 through 19	334516

Notes - 2011

Narrative:
New Hampshire's total population is just over 1.3 million, with 49% residing in rural areas and 51% in urban areas. Seventy-seven percent of New Hampshire towns are considered non-urban or rural, with urban and near urban areas located in the south east and south central regions and primarily rural areas in the western, central and northern sections. The three most urban areas are Manchester, Nashua and Concord, all located in the state's southern third. Manchester, the only New Hampshire city with a population over 100,000, is the largest city in the tri-state area of Maine, New Hampshire, and Vermont.

Hillsborough County includes the two largest cities of Manchester and Nashua and is the most densely populated area with 405,906 residents (about 30% of the total population). The White Mountain National Forest separates the south from the northernmost rural section of the state, which consists of Coos County. New Hampshire citizens in rural communities face geographic

barriers to health care such as lack of transportation and increased travel time to health care providers and hospitals.

Interestingly, although New Hampshire has no metropolitan areas, as defined by the US Census, 60% of children 19 years and younger live in urban areas and 40% of children live in rural areas. This indicates, once again, that the rural areas of the state are aging while the more urban areas of the state are experiencing population growth, including families with children. Nine percent of children in rural areas live in poverty.

Many of New Hampshire's rural areas are amenity rich areas that have seen a migration of older adults as baby boomers retire, as more people buy second homes, and as professionals choose to settle in small town communities with rich natural amenities. New Hampshire is particularily popular among relatively wealthy retirees as the tax burden is favorable with no broad based income or sales taxes. However, this often presents challenges with younger families requiring an economy based upon declining or transitioning resources, including agriculture, timber, mining or related manufacturing industries that once supported a solid blue collar middle class in these rual communities.

This information confirms what is anecdotally known throughout the state. The needs of the state vary by geography. Population, wealth and services are concentrated in the southern and eastern areas of the state. The northern areas of the state are aging and services for children are located farther apart. Health care providers are in short supply in these areas, especially in the fields of oral health and mental health services. As for all populations in northern areas, transportation needs compound these challenges. Population data drives innovative strategies such as telehealth services. Title V continues to monitor these changes to support safety net providers in developing service delivery methods to meet the needs of their specific communities.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	1315809.0
Percent Below: 50% of poverty	2.0
100% of poverty	5.7
200% of poverty	19.1

Notes - 2011

Narrative:
This Health Status Indicators provides a means to better understand the needs of our state. By monitoring the changes in levels of poverty, MCH can better anticipate the needs of community-based safety net providers that provide care low income and vulnerable families. Currently, MCH utilizes a formula that incorporates the proportion of the population in poverty within each service area into the methodology for community health center funding. This formula has been used as a model for the New Hampshire Women, Children and Infants Nutrition (WIC) Program as they re-design their service delivery system and funding methodology for SFY11.

There are several measures of income available that help provide a snapshot of the state's economy. While generally, New Hampshire is regarded as an affluent state, there are indicators that suggest that the population that is working may have have segments that are struggling. For example, the average weekly wage in New Hampshire in 2008 was, $871, an increase of 2% from 2007. This small increase ranked in the bottom fifteen states in the country and was the

smallest increase felt in the state in almost ten years. Per capita personal income in New Hampshire was $43,623 in 2008, a 1.8% year over year increase - this means that income did not outpace inflation (Vital Signs 2010 Economic & Social Indicators for New Hampshire, 2005-2008).

Although New Hampshire is fortunate to compare favorably when compared to other states in the percent of the state's population at various level's of poverty, As described, New Hampshire has not been immune from the ecomomic troubles affecting the entire country. Wages for the lowest wage-earners in New Hampshire either fell or stagnated while those for the state's top half of wage-earners grew by 5.7 percent or more and median household income for families with children has barely climbed over the last five years. (Kids Count New Hampshire Data Book 2008)

During 2008, unemployment rates rose to an average of 4%. While significantly better than national levels, the local economy is finding it harder to withstand the impacts of national economic trends. (Vital Signs 2009 Economic & Social Indicators for New Hampshire, 2004-2007)

Place also matters. In rural areas poverty rates are 8.8%; Suburban areas are 5.3%; Central City areas are 17.5%. New Hampshire's northern, rural counties reflected poverty levels higher than the state average.

As the entire country is aware, the economy is presenting challenges on all fronts. Currently, the May 2009, seasonally adjusted unemployment rate for New Hampshire has increased to 6.5%. The national rate for May 2009 was 9.4%. Maintenance of a healthy New Hampshire economy will depend on a stable and improving United States economy.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	334516.0
Percent Below: 50% of poverty	2.0
100% of poverty	7.8
200% of poverty	19.1

Notes - 2011

Narrative:
Percent of the State population aged 0 through 19 years at various levels of the federal poverty level provides a means to better understand the needs of our state. Children, especially the youngest children, in New Hampshire, as they are nationally, are disproportionately affected by poverty. By monitoring the changes in levels of poverty, MCH can better anticipate the needs of community-based safety net providers that provide care to low income and vulnerable families. By using this data, Title V examines the allocation of resources for community health centers and other safety net providers.

Parent employment is not a guarentee of a comfortable living wage and family income. In 2008, 56% (34,326) of New Hampshire children in low-income families (200% of FPL) had at least one parent who was employed full-time, year-round (National Center for Children in Poverty, 2010).

Parents without a college education often struggle to earn enough to support a family, but only 32% of adults in New Hampshire have a bachelor's degree. Even more concerning, 75% of children whose parents do not have a high school degree live in low-income families (National

Center for Children in Poverty, 2010).

New Hampshire mirrored the national economic recession and job losses and unemployment increased throughout the state in 2008- 2010. Seasonally adjusted unemployment rates rose from 4% in 208 to 5.1% in March 2008 and up to 7.1% in March 2010. While still better than national levels, the local economy is not immune to the impacts of national economic trends. (New Hampshire Economic Conditions, New Hampshire Employment Security's Economic and Labor Market Information Bureau, May 2010).

Place also matters. In rural areas poverty rates are 8.8%; Suburban areas are 5.3%; Central City areas are 17.5%. New Hampshire's northern, rural counties reflected poverty levels higher than the state average.

If you adjust for poverty in children the proportions look slightly different. According to the National Center for Children in Poverty, 24% (26,627) of children in rural areas live in low-income families; 13% of children in suburban areas live in low-income families; and 20% of children in urban areas live in low-income families.(National Center for Children in Poverty, 2010)

If you investigate even further, the data suggests that the disparities are regionally specific. In the city of Manchester, 25% of all children lived below the FPL in 2007. In contrast, in Nashua, the next largest city in the county only 8% of children are in poverty.

These trends of poverty in the northern and western rural areas of the state and in urban Manchester are similar to those described throughout this Annual Report and throughout the Title V Needs assessment. MCH tries to address these disparities through funding formulas for community health centers based on need and through ensuring that enabling services are placed in communities most in need.

F. Other Program Activities

NEW HAMPSHIRE BIRTH CONDITIONS PROGRAM: Dartmouth Medical School (DMS), SMS, MCH, WIC, and Early Intervention continue to collaborate on the implementation of a birth defect surveillance system for NH. Funded through a CDC cooperative agreement, the project is: establishing a high quality, statewide, comprehensive birth defect surveillance system; expanding NH folic acid education and birth defect prevention activities; and improving access to health care and early intervention services for infants with birth defects. In June 2008, the program was established in law to be under the authority and direction of DHHS. While it will continue to be housed at DMS, a new advisory board structure monitors and provides oversight to the program. The MCH and SMS Directors are active members of the project's Advisory Council. MCH also provides oversight of the "opt out" process for inclusion in the program. MCH provides support as appropriate, such as development of the MOU between DHHS and Dartmouth, and a letter outlining the project to encourage hospital participation.

ELDERLY FALLS: Preventing falls, particularly among older adults, can greatly impact injury-related deaths. . Falls are not an inevitable consequence of aging and proven effective strategies exist for decreasing the risk. The Injury Prevention Program within MCH facilitates the New Hampshire Falls Risk Reduction Task Force (Task Force). In 2009, the Task Force attended to the prioritized goals it set for itself during 2008's yearlong web-based process survey. A website is in development and is planned to launch on National Falls Awareness Day on September 21st, 2010.

The Task Force continues to promote routine falls screening in primary care settings, co-inciding with the release of the new American Geriatrics Society guidelines in the winter of 2010. This work is happening in collaboration with the Northern New England Geriatric Education Center at

Dartmouth Hitchcock Medical Center.

The Task Force also completed a survey of E-911 calls during one week each in the winters of 09 and 10 and summers of 09 and 10, resulting not only in informative season specific data, but also confirming that falls are the number one E-911 call in the state. Results indicated approximately 30% more calls during the winter weeks. There was more of an equitable share of calls between men and women in the weeks in winter than in the summer when women were three times more likely to call. Geographic locations varied and were not consistent.

SEXUAL VIOLENCE PREVENTION: The Injury Prevention Program with funding from the Centers from Disease Control (Sexual Violence Grant and Preventive Health and Health Services Grant) contracts with the New Hampshire Coalition Against Domestic and Sexual Violence who in turn subcontracts with 13 local crisis centers to provide primary sexual assault prevention education activities within local communities throughout the state.

The sexual violence prevention plan was completed and will guide the efforts of grant-funded activities. New Hampshire's plan places a large emphasis on infrastructure building and professional development, which is consistent with what is happening on a national level.

POISON PREVENTION: A new educator from the Northern New England Poison Center Jocelyn Villiotti, started work in April 2010. Ms. Villiotti sits within the Injury Prevention Program within the Maternal and Child Health Section.

The Poison Center is currently focusing its outreach efforts on two large projects. One focuses on seniors in rural Coos County regarding medication safety and involves distribution of revised brochure as well as performances by a senior acting troupe. The other revolves around the Community Partner Program, whereby community members take online courses in Poisoning 101, Medication Misuse, and Inhalant Abuse.

HEALTHY CHILDCARE NH (HHCNH) has continued to work with Child Care Licensing and the Child Development Bureau to support all child care providers with health and safety best practices, including mandated training in medication administration. Additionally, HCCNH has been the liaison with childcare in developing strategies for obesity prevention programs such as the "I am Moving, I am Learning" curriculum.

TEEN DRIVING: The teen driving group is coordinated by the Adolescent Health/Injury Prevention Program and includes region-wide professional groups. The group is pursuing a seatbelt initiative in schools and collaborating on law revisions for extended graduated driver's licensing (GDL).

AUTISM LEGISLATIVE COMMISSION- MCH staff have been participating in a commission mandated by NH House Bill 236, to develop a report and recommendations, released spring 2008, on improving awareness, services, training, and reimbursement related to serving the needs of children and young adults with Autism Spectrum Disorders. Among the recommendations was that a council be formed to continue the work of the commission. In 2008, legislation was passed to form the NH Autism Council to continue the work of the Autism Commission. MCH staff participate in several of the workgroups including Screening and Early Diagnosis Workgroup,

NH HEALTHY HOMES -- MCH has been part of spearheading the planning process to move the Childhood Lead Poisoning Prevention Program (CLPPP) to a Healthy Homes Program, and to move statewide implementation efforts of a "One Touch" information and referral system. The CLPPP has formed a Healthy Homes Steering Committee to review the priorities of the statewide strategic plan and to be the coordinating body to oversee and assist in implementing healthy homes activities statewide.

TEXT4BABY: MCH and WIC have co-sponsored an initiative to promote this innovative mobile phone based health promotion campaign for pregnant and parenting mothers. Since the inception of the program in New Hampshire on April 2010, over 300 women have signed up for this free service. Pregnant women merely send a text message to receive three texts a week about maternal and child health specially geared toward their child's due date until the baby's first birthday.

EMERGENCY SERVICES for CSHCN: Several State of NH entities have been working together to try to improve the outcomes of emergency response situations for children with complex and chronic health conditions. These groups are: Department of Safety-Division of Emergency Services, New Hampshire Family Voices, the EMSC, and SMS. Surveys responses from EMS responders and Hospital staff will guide future activity.

G. Technical Assistance

In March 2010, the New Hampshire Maternal and Child Health Section (MCH) utilized technical assistance from Mr. Russell Funk, Independent Consultant from Louisville, Kentucky and author of many books such as "Reaching Men: Strategies for Addressing Sexist Attitudes, Behaviors, and Violence" to help address the State priority of maintaining safe and healthy environments for pregnant women, families and children. Mr. Funk worked in collaboration with staff from MCH and the NH Coalition Against Domestic and Sexual Violence (Coalition) to help advance the work of NH Sexual Violence Prevention Plan.

The two-day workshop, held on March 25th and 26th 2010 was based on the following:

- Best science and practical strategies in engaging adolescent boys/men in violence prevention (particularly sexual violence prevention).
- Incorporation of above strategies into existing primary prevention activities and practices
- Gender stereotyping, specifically as it relates to violence and sexual violence prevention.

Approximately forty participants, including at least two staff from each of 13 Coalition member programs (crisis centers) attended. All participants completed ten open-ended questions at the end of day two to evaluate the success and learning opportunities of the training session.

One of the goals of the technical assistance was to increase the current and future capacity of prevention educators and other colleagues in the state in the primary prevention of sexual violence. This was in addition to utilizing this as a piece of the core competency training outlined in the new state sexual violence prevention plan. The development of the core- competency training guidelines has not been finished. The former goal was met by the answers to the questions, "How useful did you find this training?" and "How can you apply what you've learned today to your everyday work?"

"Very useful in that it provided exercises and information that I can use when speaking to men, I am trying to engage them in discussion about the work to end violence."

"Great frameworks and tools for organizing around engagement."

"Good review of many theories/philosophies that I was familiar with but hadn't applied to engaging men. I learned a lot about the complexity of addressing sexist violence with men you're trying to engage (defensiveness, the connection between sexism and violence not being obvious to men)".

"Increased awareness of opportunities to involve men. Approaching current activities from a new perspective."

"At the end of my presentations with the high schools I will dedicate some time to specifically ask questions to the students regarding why a male should care about sexual assault".

"That you engage men doesn't mean bringing them from 0-60 in one push, that even a little positive change is a win".

Most participants valued this training as a basic component of violence prevention.

"Make this discussion a regular long term component pertaining to how we work to end violence".

"Build engagement into existing work, recognize existing allies".

"Add this part to advocate and prevention training; change our agency policies about how we approach male clients, both formal and informal; change format of presentation to more dialogue".

Some of the participants listed challenges to implementation.

"This was helpful for thinking through but implementing is another thing and it's hard to think through without the rest of the organization. Sometimes it was like having homework in a class and having the class keep going before you've been able to do or process your homework and the fullness of the first lesson. So much but I'm still processing so it is tough to articulate."

"Our most limited resource is time".

"System based sexism that is hard to recognize yet is constantly present to reinforce wrong behaviors".

"At the Coalition level I think there is still resistance to engaging men in a manner that meets them where they are at on the continuum of understanding DV/SA/IPV/sexism".

At six months and one-year post workshop, there will be another evaluation to see what technical assistance participants continue to need as well as completed implementation.

ADDITIONAL REQUESTS:

Looking forward, MCH anticipates that technical assistance will be needed from federal partners as New Hampshire establishes its first Maternal Mortality Review Panel and Infant Mortality Review Panel.

The Maternal Mortality Review Panel was established in law in June 2010 to conduct comprehensive, multidisciplinary reviews of maternal deaths. The Panel, which includes the Title V Director, shall submit an annual report beginning on June 1, 2011 to the legislative oversight describing adverse events reviewed by the panel, including statistics and causes, and outlining, in aggregate, corrective action plans, and making recommendations for system change and legislation relative to state health care operations. As per the legislation, the NH DHHS Commissioner may delegate to the Northern New England Perinatal Quality Improvement Network (NNEPQIN) the functions of collecting, analyzing, and disseminating maternal mortality information, organizing and convening meetings of the panel, and other substantive and administrative tasks as may be incident to these activities.

Because this process is new to New Hampshire, Title V hopes that federal partners from CDC, HRSA and peers from other states have standards, experience, and best practices to share as we develop Administrative Rules and protocols.

Much like the Maternal Mortality Review, the Infant Mortality Review Panel was also newly enacted in June 2010 to study New Hampshire's rate of infant mortality and develop proposals for remediation. Unlike the Maternal Mortality Review Panel, this legislation did not specify

community and professional partners to be present and active on the commitee. It is unclear what role the legislature would like Title V to play in the development in this committee, but we feel it is important to have technical assistance ready for their use, if appropriate.

TECHNICAL ASSISTANCE FOR SPECIAL MEDICAL SERVICES (CSHCN Program)

I. Strategic Planning

Special Medical Services (SMS) will be requesting technical assistance, consultation, and facilitation to conduct a formal Section-level strategic planning process to include the review of care coordination, clinic services, program design, needs assessment, cultural & linguistic competence and public awareness/marketing. This process with take into account all identified priorities for NH CSHCN and all National and State Performance Measures for CSHCN.

Assistance is needed to help guide the SMS staff in the identification of the technology, policies, and funding strategies necessary to achieve the goals of SMS. Special Medical Services offers infrastructure-building expertise to develop the NH systems of health care for CSHCN, in balance with the direct provision of community-based care coordination.

To fully actualize the principles of family-centered, community-based care, both the direct provision of service by state coordinators, and the provision of consultation to other public and private providers, is crucial. Facilitated planning will encompass the priorities and needs of NH CSHCN, their families, and the provider community. The core issue is the defining of future applications of the SMS resources and determining the nature and extent of direct services provided by SMS staff and contractors, within the overall CSHCN health care system. Defining exactly which CSHCN subpopulations, which geographic areas of the state, what family impact factors, eligibility criteria, and other such specifics, is necessary in order to target the limited resources to the identified priority needs in the most effective manner.

SMS has significantly changed the direction of its services but formal reflection and strategic planning has not taken place. SMS needs to develop a vision and mission statement and a planned approach to meet the needs of CSHCN in NH

II. Disparities and CSHCN in NH.

SMS has seen a significant increase the number of diverse populations accessing services. A formal evaluation is needed related to incorporating cultural and linguistic appropriate components into provided services. The intent is to request technical assistance to conduct this evaluation. This will be done in concert with a formal plan on program evaluation that is being completed by an MCH funded intern Summer 2010. This will be a standardized and comprehensive framework for ongoing program evaluation for SMS for the next five years that is responsive to the needs of families of CSHCN and to federal and state required reporting.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	1997739	2002759	2002939		2002759	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	7170215	6381079	6733801		7122044	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	870000	684495	870000		870000	
6. Program Income *(Line6, Form 2)*	0	0	0		0	
7. Subtotal	10037954	9068333	9606740		9994803	
8. Other Federal Funds *(Line10, Form 2)*	755805	757653	790387		687964	
9. Total *(Line11, Form 2)*	10793759	9825986	10397127		10682767	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	728624	718602	712920		763762	
b. Infants < 1 year old	1246191	1199801	1214601		1285982	
c. Children 1 to 22 years old	3902334	3521064	3765239		3863084	
d. Children with	2534100	2352891	2909998		3041788	

Special Healthcare Needs						
e. Others	1086790	935487	551070		561147	
f. Administration	539915	340488	452912		479040	
g. SUBTOTAL	10037954	9068333	9606740		9994803	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		100000	
c. CISS	140000		140000		140000	
d. Abstinence Education	94901		94948		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	306260		310795		297964	
j. Education	0		0		0	
k. Other						
NH Univ Newborn Hear	120000		150000		150000	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	4131934	3516045	3660298		3533845	
II. Enabling Services	2340590	2044145	2288433		2298251	
III. Population-Based Services	890576	883804	851889		911878	
IV. Infrastructure Building Services	2674854	2624339	2806120		3250829	
V. Federal-State Title V Block Grant Partnership Total	10037954	9068333	9606740		9994803	

A. Expenditures

Expenditure trends:

The following factors have had, or are likely to have, an impact on MCH-related expenditures

Cost Allocation and Administrative Costs:
As noted SMS will continue to work with financial manangement to insure that budget planning for the next biennium will more clearly reflect planned spending and revenue.

Other State Budget Reductions:
It can be anticipated that the primary impact of State line item freezes or budget reductions will be the expenditure of fewer dollars than planned. Title V has focused a great deal on engineering any budget reductions so that they have least impact on services possible. However, as more

reductions are anticipated in the next fiscal year this will become increasingly difficult.

Staffing Vacancies:
Title V is currently experiencing some capacity issues related to both "frozen" vacancies and some position reassignments/layoffs. Currently all vacant DHHS positions are "frozen" until such a time as a request to fill the position is granted by the Commissioner. DHHS guidance for additional budget reductions are focusing on transformation of operations to maximize efficiencies. However, this does reflect as decreased expenditures than what had been planned with the expectation was that Title V programs would be fully staffed.

For the purpose of this application, "significant expenditure variation" is defined as an expended amount in any line item that is greater than 10% above or below the budgeted amount for that year. The following lines on Forms 3-5 adhere to this criterion:

Form 3:
The expended amount for Line 3, State Funds, was 11% less than originally budgeted. This line is reflective of the many mandatory state budget reductions in travel, supplies, equipment and hiring freezes that began in SFY09. Reductions in expenditures are also reflective of an effort of Special Medical Services (SMS) work within its new organizational alignment to better understand administrative costs to get at a "truer" budget of State General Funds.

The expended amount for Line 5, Other Funds, was 22% less than originally budgeted. These funds represent Filter Paper Fees paid by hospitals for Newborn Screening. Due to a continued declining number of births, the contract for newborn screening has been less than originally budgeted, as well as contracts for Metabolic Consultation.

Form 4:
Line Ie: The expended amount for Others was less than the budgeted amount by 14%, due mostly to the re-assignment and ultimately the elimination of the Catastrophic Illness Program from SMS. Since the program was reorganized to another Bureau. These funds were all State General Funds.

Line If: The expended amount for Administration was less than the budgeted amount by more than 37%. This significant reduction was due, in part, to the cost allocation method used by New Hampshire, in addition to a reduction in administrative functions within MCH. It should be noted that in the current structure between MCH and SMS, SMS does not capture "administrative" costs. This is also a significant driver in the discrepancy between the budgeted amount and the expended amount.

Form 5:
In order to move towards the MCH pyramid, funds have slowly moved "down" the pyramid of services to support increased infrastructure, population based, and enabling services. Both arms of Title V, MCH and SMS have made efforts to fund less direct services and provide more support for the foundation of the pyramid.

This budget also continues to reflect the overall downsizing of the Title V Partnership, due to the combined factors of state budget cuts and "right sizing" budgets of previous years.

Line I represents a 15% decrease in Direct Services. Fewer clinical services were provided directly by SMS staff.

Line II shows an 13% reduction in enabling services. This is due to reduced staff time in SMS devoted to providing direct enabling services for families.

The remaining lines in population based activities and infrastructure did not have significant budget variation.

B. Budget

HOW FEDERAL SUPPORT COMPLEMENTS THE STATE'S TOTAL EFFORTS

Federal support is essential to the preservation of a comprehensive Title V program in New Hampshire. The Title V Maintenance of Effort and required match help assure a basic funding level for state and local maternal and child health programs. During times of necessary fiscal constraint, difficult decisions must be made about decreasing or eliminating programs and services. In these situations, Title V block grant dollars work to remind all states of the importance of funding MCH activities.

At the community level, Title V dollars help fund numerous local agencies and projects that provide a wide variety of services to MCH populations. In these communities, Title V dollars also help leverage funds from municipalities, businesses, and private foundations to serve the Title V mission. Often, simply the fact that an agency contracts with MCH gives them increased credibility with other funders and an increased ability to leverage funds from small, community foundations, the United Way, or other fundraising efforts.

AMOUNTS UTILIZED IN COMPLIANCE WITH THE 30%-30% REQUIREMENTS

As shown on Form 2, New Hampshire complies with Federal 30%-30% requirements. Services for CSHCN are provided through the SMS; $834,088, or 41.65% of New Hampshire's Title V allocation, is appropriated to the SMS budget for FY 2011. Using a memorandum of understanding (MOU) developed between the the two sister programs in 2008, and revised in 2009, that clearly delineates the roles, responsibilities and commitments between the two programs, funds are easily appropriated through a well-defined methodology. The ultimate goal of using this formalized approach was to ensure that expenditures continued to be more closely aligned with the proportions suggested by the MCH pyramid while providing a mechanism to ensure collaboration in joint Title V goals.

Preventive and primary care services for children are provided through the MCHS; costs include direct care and support services through contracts with community agencies, population based program costs, and infrastructure costs for all MCHS children's services. The total of $795,173, the amount projected for children's services for FY 2011, is 39.54% of the Title V allocation. Administration is projected to remain at 5.041% at $108,440.

SOURCES OF OTHER FEDERAL MCH DOLLARS, STATE MATCHING FUNDS & OTHER STATE FUNDS USED TO PROVIDE THE TITLE V PROGRAM

Sources of other Federal dollars, as indicated on Form 2, include grants from the Maternal and Child Health Bureau (MCHB) and other Federal agencies.

SSDI Grant: $100,000
These funds are used to address New Hampshire's capacity to improve performance on Health Systems Capacity Indicator 09A and to develop linkages between MCH program datasets and New Hampshire birth files.

Universal Newborn Hearing Screening Grant: $150,000
These funds are used to establish New Hampshire's universal newborn hearing screening program, including implementation of quality assurance standards and a data-tracking initiative.

ECCS Grant: $140,000

This grant is used to fund a strategic planning project for early childhood comprehensive systems. This planning project is in its final year, and will address strategies to strengthen the five focus areas highlighted in the MCHB Strategic Plan for Early Childhood. The ECCS Coordinator plays a critical role in in aligning early childhood efforts throughout DHHS and is the key liaison for the Early Childhood Advisory Council and the key contact for the Affordable Care Act Home Visiting initiative.

CDC funds include support for the Rape Prevention and Education Grant (RPEG), $160,196 and Early Hearing Detection and Intervention (EHDI) program, $150,000.

NH does not receive funding for PRAMS.

All State matching funds, as indicated on Form 2 and explained previously in Achievement of Required Match, are
appropriated from the New Hampshire General Fund during the State's biennium budget process.

Due to the configuration of New Hampshire's public health infrastructure and its system of contracting with local agencies to provide MCH services, there are no sources of "Local MCH" or "Other State" funds included in the MCH or SMS appropriations, as indicated on Form 2.

SIGNIFICANT BUDGET VARIATIONS FROM FORMS 3-5

For the purpose of this application, "significant budget variation" is defined as an increase or decrease in any budgeted line item that is greater than 10% from the budgeted item in the previous year. The following lines on Forms 3- 5 adhere to this criterion:

Form 3:

FY2011 reflects significantly fewer Other Federal Funds than in FY2010. The leading contributor to this is the loss of the 510 Abstinence Grant. Although the Affordable Care Act has noted that there will be opportunities for Abstinence funding in FY 2011, it is unclear at the publication of the Annual Report what the funding will be and if NH will apply for it. Additionally, other federal grants, especially those from CDC, such as Rape Prevention and Education (RPEG) and Early Hearing Detection and Interventuion (EHDI) have all seen smaller decreases in the past year that contribute incrementally to this decrease in federal funds.

It should be noted however that in next year's Annual Report, that New Hampshire anticipates additional Home Visiting, Teen Pregnancy (PREP) funds and perhaps other federal opportunities that will more than offset these reductions. It is just unclear at this time what those final budgeted amounts will be.

Form 4:

No budgeted amounts per population served for FY 2011 differ more than 10% from amounts for FY 2010.

Form 5:

Form 5 is reflective of the slow shift of moving Title V services down the MCH pyramid. While there is no significant difference in the amount Expended in 2009, Budgeted in FY 2010 and Budgeted in 2011, in Direct Health services, there funds continue to decrease. The significant changes occur in the below in Lines III and IV where there are increases are reflected in the amount that is budgeted for Population-based activities and Infrastructure Building Services. Contributors to this shift include fewer the final shift of the Catastrophic Illness Program out of SMS (thus out of Direct Services); increased allocation of time to injury prevention(Population-based services); increased newborn screening fees (Population-based services); and increased

federal funds for Early Childhood Comprehensive Systems (Infrastructure-building).

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.